Program Evaluation

KENTUCKY MEDICAL ASSISTANCE PROGRAM

OFFICE OF PROGRAM REVIEW & INVESTIGATIONS

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LEGISLATIVE RESEARCH COMMISSION

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Committee for Program Review and Investigations

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FOREWORD

In May, 1993, the Program Review and Investigations Committee directed staff to conduct a study of the Kentucky Medical Assistance Program, to identify problems related to a program which consumes 22% of the state's operating budget. The Program Review and Investigations Committee adopted the initial report on October 11, 1993. Additional work and follow-up has continued through December, 1995.

The report is the result of dedicated time and effort by the Program Review staff and secretaries Jo Ann Paulin Blake, Susie Reed and Bonnie Jezik. Our appreciation is also expressed to the Cabinet for Human Resources and the staff of the Department for Medicaid Services.

Don Cetrulo
Director

Frankfort, Kentucky
February, 1996

MEMORANDUM

TO: Governor Paul Patton
Members of the General Assembly
Affected Agency Heads and Interested Individuals

FROM: Representative Jack Coleman, Chair, 1994-96
Senator Joey Pendleton, Vice Chair, 1994-96
Senator Susan Johns, Chair, 1993-94
Representative Hank Hancock, Vice Chair, 1993-94

DATE: February, 1996

RE: Program Evaluation: Kentucky Medical Assistance Program

Attached is the final report of a study of the Kentucky Medical Assistance Program directed by the Program Review and Investigations Committee. The report was adopted at the Committee's October, 1993 meeting. Additional research and follow-up activity continued through December, 1995. The initial report presents findings and recommendations regarding the state plan, financial accountability, financial recovery and drug utilization. The study lists potential annual savings and recoveries from identified sources which total $211 million.

The results of the study indicate several problematic areas: 1) The Cabinet for Human Resources should require an independent evaluation of the effectiveness of the KenPac program; 2) A private and independent audit of the Medicaid Management Information System (MMIS) should be commissioned immediately by The Cabinet for Human Resources; 3) The Cabinet for Human Resources should audit the Medicaid Assessment Improvement Trust and the Medicaid Assessment Revolving Trust on a regular basis and in compliance with state statutes; 4) The Cabinet for Human Resources should expedite the signing of the FY 1992-93 Interagency Agreement and perform internal monitoring of the contract by auditing policy interpretation and criteria for eligibility determination and related programs; 5) The Cabinet for Human

Resources should develop policies and procedures governing forgiveness of debt owed the Medicaid program; 6) The Cabinet for Human Resources should determine the legality of making advance payments and discharging overpayments; 7) The Cabinet for Human Resources should develop policies to define hardship; 8) The Department of Medicaid Services should develop policies and procedures that reflect applicable state and federal policies on check retention; 9) The Cabinet for Human Resources should insure that disclosures are obtained from all provider types and kept current; 10) The Department of Medicaid Services should be more aggressive in pursuing overpayments and third party liabilities; 11) The Department of Medicaid Services should develop guidelines and criteria to define appropriate utilization to meet recipient needs and recognized standards of health care; 12) The Department of Human Resources should study the effectiveness of amending the state plan to request a waiver to restrict freedom of choice provisions.

At the request of this Committee, the Auditor of Public Accounts reviewed utilization of the Non-Emergency Medical Transportation Program and certain aspects of the Medicaid provider enrollment process. Also the Auditor of Public Accounts contracted with Coopers and Lybrand to review the contract between Electronic Data Systems (EDS) and the Department of Medicaid Services, an audit of the Medicaid Management Information System (MMIS), and an audit of the Medicaid Assessment Improvement Trust (MAIT) and the Medicaid Assessment Revolving Trust (MART) accounts.

Questions or requests for additional information should be directed to Dr. Joseph Fiala, Assistant Director, Office for Program Review and Investigations.

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Chart #3 lists the potential annual savings and recoveries of between $170 million and $211 million from identified sources.

State Plan

The state plan is a comprehensive written statement submitted by the agency, describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX and other applicable official issuances of the Department.

Waivers--A Management Tool

Waivers are intended to provide the flexibility needed to enable states to try new or different approaches to the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients.

KenPAC Waiver Program

One example of a waiver program in Kentucky is the Kentucky Patient Access and Care program. KenPAC began operating in 1986 and was intended to provide AFDC and AFDCA-related populations with managed health care. The program goals were to assure needed access to health care, provide continuity of care, prevent unnecessary utilization and costs, and strengthen the patient and physician relationship.

Cost saving estimates vary. No clear or concrete answers have been derived. Problems regarding utilization have been noted in various studies.

RECOMMENDATION #1: KenPAC Should Be Evaluated.

The Cabinet for Human Resources should require an independent evaluation of the effectiveness of the KenPAC program. The program should be redesigned to address any deficiencies in cost containment, service utilization, program education, program availability or management fees. The evaluation should be completed before the wavier renewal application is submitted to the federal Department of Health and Human Services.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

Such evaluation will not, in all likelihood, begin until on or after July 1, 1996.

Staff Follow-up Response, January 1996

Over utilization of services continues to indicate a weakness in the program, as was evident in the initial study conducted by Program Review in 1993. An evaluation of KenPAC should be expedited.

RECOMMENDATION #2: MMIS Audit

A private and independent audit of the MMIS system should be commissioned immediately by the Cabinet for Human Resources.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The Coopers and Lybrand review completed on March 11, 1994 found very few and minor exceptions with the EDS operated MMIS and because EDS is no longer the fiscal intermediary for Medicaid, we would like to defer our report on actions taken.

Staff Follow-up Response, January 1996

A contract with Coopers and Lybrand was initiated and the final report was issued on March 11, 1994. The report identified potential savings of up to $209 million in the following areas: utilization control, enhanced accountability and improved efficiency.

Medicaid Trusts Need Auditing

Under the Hospital Indigent Care Assurance Program (HICAP) program, which ended on July 1,1993, two trust funds were created: MAIT (Medicaid Assessment Improvement Trust) and MART (Medicaid Assessment Revolving Trust). KRS 205.577 requires DMS to conduct annual audits of MART to ensure that amounts paid to providers are correct. Likewise KRS 205.590 requires that

prior to authorization of any expenditures or any transfer of MAIT funds for CHR administrative expenses, there must be legislative and executive review. No comprehensive audit of the trust funds has been performed.

RECOMMENDATION #3 : Trust Fund Audit

The Cabinet for Human Resources should audit the two funds on a regular basis and in compliance with state statutes. The State Auditor's Office should provide copies of its audit to the Appropriations and Revenue Committee, the Health and Welfare Committee, and the Program Review and Investigations Committee.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

No response necessary.

Staff Follow-up Response, January 1996

On March 25, 1994 an audit of the Medicaid Assistance Revolving Trust (MART) Fund was issued. The audit was performed by Coopers & Lybrand and involved the period from inception (July 13, 1990) to June 30, 1991, and the years ended June 30, 1992 and 1993.

DSI Eligibility Determination Audit

The Department of Social Insurance provides eligibility determination services under a $15 million contract with DMS. DMS and DSI currently operate the Medicaid eligibility determination and related programs without a signed contract; the FY 1992-93 contract expired on June 30, 1993.

RECOMMENDATION #4: DSI Eligibility Determination Audit.

The Cabinet for Human Resources should expedite the signing of the FY 1992-93 Interagency Agreement and perform internal monitoring of the contract by auditing policy interpretation and criteria for eligibility determination and related programs.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The Division of Program Development and Budget monitors the implementation of the eligibility contract. Staff in the Policy Analysis and Eligibility Branch review all proposed eligibility manual material prior to its use by DSI field staff to ensure conformity with policy. The Branch and other staff

also monitor the audits of the federal Medicaid Eligibility Quality Control (MEQC) system.

Staff Follow-up Response, January 1996

The interagency agreement between the DMS and the DSI to perform recipient eligibility processes is currently $23.5 million. This is an $8.5 million increase since 1993. The Program Review recommendation urged the DMS to review case files to insure policies were interpreted and applied correctly.

Necessity for Policies and Procedures

A lack of written policies and procedures in several areas raises questions about the level of discretion used to make decisions in the areas of advance payments, discharges, and hardship. The practice of retaining provider checks for extended periods does not seem to be good fiscal policy. Specific authority for advance payments and discharges is unclear. Hardship is the primary reason given for the need to make advance payments, to authorize payback schedules and to make discharges.

RECOMMENDATION #5: Policies and Procedures Governing Forgiveness of Debts.

The Cabinet for Human Resources should develop policies and procedures governing forgiveness of debts owed the Medicaid program. These policies should address criteria for determining financial hardship and provider disclosure information and should ensure compliance with federal and state laws. A single authority within the Department should be designated for reviewing and approving these exceptional practices and should ensure proper monitoring and tracking within MMIS.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The CHR has no procedures in place, as such, to "forgive" debts owed to Medicaid. The Cabinet does make every effort to collect on debts determined to be owed to DMS after the appropriate appeal process has been followed. The Department will not consider any offer for a settlement unless the provider's offer includes an amount greater than or equal to the federal share amount. No settlement agreement is final without consultation between the Department for Medicaid Services and the Office of the Counsel.

Staff Follow-up Response, January 1996

The CHR should develop policies and procedures to ensure consistent actions and actions that ensure the State's interest are in place when lesser amounts

are accepted in settlements. Settlement agreements to collect "at least" the federal share may not be in the state's best interest. Criteria should be established which ensure federal and state interests are protected.

Fiscal Accountability

A preliminary examination of the Department of Medicaid Services (DMS) fiscal practices revealed a lack of written policies and procedures and questionable practices in the areas of advance payments, discharges, retaining provider checks and declaring hardship. In addition, a need for expanded or continued auditing was identified in Kentucky's Management Information System, Medicaid Trusts, and DMS' interagency agreement with the Department of Social Insurance (DSI).

RECOMMENDATION #6: Review the Legality and Necessity for Making Advances and Discharges.

The Cabinet for Human Resources should determine the legality of making advance payments and discharging overpayments. If the Cabinet determines there is a legal authority to continue these practices, it should formalize the processes by developing regulations that will specify when, how, and to whom advances and discharges should be made. In addition, regulations should specify a central authority for authorizing advances and discharges, describe measures for tracking and monitoring the claims involved, and insure that these transaction are appropriately recorded and reflected in the management information system in a manner that will allow easy retrieval.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

There are no regulations that address the authority for Medicaid to make advance payments. Interim payments are only issued when it is deemed necessary to prevent the interruption of services provided to Medicaid recipients.

Effective December 1, 1995, Medicaid changed its fiscal agent from EDS to UNISYS. UNISYS has been unable to correctly process claims for payment for some provider types; therefore, Medicaid has issued interim payments to virtually all providers based upon pending claims or provider certifications of services provided to Medicaid recipients.

Staff Follow-up Response, January 1996

The CHR should develop policies that comply with OAG 82.281 for allowing advance or interim payments. Development of this policy appears more important today than ever before, with the DMS's situation involving the transition of a new fiscal agent and the use of interim payments.

RECOMMENDATION #7: Develop Policies for Hardship Requests.

The Cabinet for Human Resources should develop policies to define hardship. In addition, policies and procedures should specify a central authority for authorizing payouts, types of documentation required to prove hardship, timeframes for submitting the documentation, appeal rights, and methods that will be used to verify provider documentation.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

No Response Necessary.

Staff Follow-up Response, January 1996

Policies were adopted in June 1995, which should provide consistent implementation of this activity.

RECOMMENDATION #8: Need for Policy and Procedures on Check Retention.

The Department of Medicaid Services should develop policies and procedures that reflect applicable state and federal policies on check retention.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The regulation regarding the withholding of payments has been provided. A report of escrow activity as of November 30, 1995, has been provided.

Staff Follow-up Response, January 1996

The Medicaid study revealed the DMS practice of retaining checks for providers who had questionable activity regarding their account. Program Review questioned the need to obligate state and federal funds by retaining uncashed/unissued checks or escrowing funds. CFR 433.40 (c) states, "If a check remains uncashed beyond a period of 180 days from the date it was issued; i.e., the date of the check, it will no longer be regarded as an allowable program expenditure."

The Medicaid study in 1993 identified checks being held for 11 months. The PW Escrow Provider Report of December 19, 1995, cited 35 checks and/or funds being held since 1994. No dollar amounts were available, since the fiscal agent is unable to retrieve this data.

Disclosures of Ownership Interest

Disclosures of ownership and control are required by federal law, to ensure the integrity of the Medicaid program. Federal law requires most Medicaid providers and fiscal agents to disclose the identity of any individuals with direct or indirect ownership greater than five percent.

Disclosures are not always available or current. Currently the Division Of Licensing and Regulation of the Office of Inspector General collects ownership information on providers it surveys and certifies for participation in the Medicaid program. A significant number were found to be inadequate, because no information was given, or the information was incomplete.

RECOMMENDATION 9 The Need for Disclosures.

The Cabinet for Human Resources should insure that disclosures are obtained from all provider types and kept current.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The Department for Medicaid Services has taken the initial steps in its effort to gather information from Medicaid providers relative to the disclosure of ownership.

Staff Follow-up Response, January 1996

Disclosure of ownership and control are required by federal law, to ensure the integrity of the Medicaid Program.

Although the need for the DMS to collect and analyze disclosure information should be paramount, the response from the Department indicates it has only taken the "initial" steps in its effort.

Financial Recovery

A preliminary look at recovery of Medicaid overpayments from recipients and providers revealed that little has been done over the last 3 years in the way of recovering recipient overpayments, especially those below $1,000. Over six million dollars in provider overpayments remains unpaid. Another form of recovery involves third party liabilities (TPLs).

A DMS official said that Medicaid Services is now planning to expand its interagency agreement (contract) with DSI to include recovering recipient overpayments. The Commissioner of DSI said that work is almost completed to transfer Medicaid recipient overpayments that would not be sent to court.

EDS reports provider overpayment balances of more than $6 million. Department of Medicaid Services staff stated that several divisions and programs are doing recoupment. So far, it has been determined that recoupments are being requested through the Division of Reimbursement Operations, the Surveillance and Utilization Review System (SURS) Branch and KenPAC.

Over $1.4 million is outstanding on SURS accounts receivable. The SURS Branch is responsible for reviewing Medicaid billing and use of services for indications of fraud and abuse.

According to EDS, SURS requests for 220 providers were identified for Fiscal Years 1992 and 1993. Their combined overpayments totaled more than $2.1 million as of May 21, 1993.

Third Party Recoveries

The Medicaid program is designed to be the payer of last resort. Some services paid for by Medicaid may be the responsibility of other parties or insurers. DMS pursues these Third Party Liabilities (TPLs) to recover costs. Two methods are used in most states, Kentucky included, to pursue TPLs once they are identified. The first method, known as **cost avoidance**, denies payment from Medicaid, and forces the provider to seek payment from the liable third party. The second method, known as **pay and chase**, pays the provider for services and then seeks recovery from a liable third party.

Kentucky does not save as much in cost avoidance as other states. Additionally, Kentucky is not as aggressive in pay and chase as other states. Kentucky's fiscal agent collected $11.5 million of $94.8 million in TPL accounts receivable. DMS reported that total third party recoveries from pay and chase activities for FY 1989 through FY 1993 totaled over $16.8 million.

Kentucky's fiscal agent has more TPL responsibility in Kentucky than those agents of other states. One of the major differences between Kentucky and the two other states interviewed is the role of the fiscal agent in pursuing TPL. In its capacity as fiscal agent for Kentucky, EDS is responsible for identifying TPLs, pursuing payment of liable third parties, and receiving payments from third parties.

RECOMMENDATION #10: DMS Should Be More Aggressive in Pursuing Overpayments and TPLs.

DMS should increase its efforts in the areas of recipient and provider overpayment recoupments. DMS should work more aggressively towards identifying potential TPLs and pursuing payment of TPLs, to increase cost

savings in the Medicaid program. Strategies for TPLs that could be utilized to implement this recommendation include:

- **Performing data matches with more private insurance companies to identify potential TPLs.**
- **Lowering the threshold on accident and trauma claims.**
- **Pursuing collection of identified TPLs more aggressively by not closing cases for lack of response.**
- **Investigating the feasibility of establishing a TPL collection unit under DMS.**
- **Investigating the feasibility of employing private collection agencies in TPL collection.**
- **Considering the feasibility of billing Medicaid recipients if a potential TPL exists.**

Drug Utilization

Codeine compounds are the most prescribed scheduled drugs. The majority of top 100 codeine prescribers and suppliers are located in Eastern Kentucky. Six top 100 codeine physician practices and pharmacies have the same address. The majority of the top 200 Medicaid recipients utilizing narcotics are institutionalized.

Surveillance and Utilization Review

The Surveillance and Utilization Review Branch (SURS) reviews providers and recipients who "except" the norm or have a higher than average utilization rate than their peers. DMS has never placed a provider on Lock-out. There appear to be some questions regarding what actions the SURS Branch may take if they do detect abusive or questionable prescribing practices.

SURS staff indicate that a lack of directives, guidelines or criteria to define "substantially in excess of recipients needs" or "professionally recognizes health care standards" limits their authority.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

Information received from agency provided the following information.

Accounts receivable for periods ending:

November 30, 1994	November 30, 1995
Under 45 days	Under 45 days
$2,964,206	$4,573,546
Under 90 days	Under 90 days
$4,466,122	$2,225,875
Over 90 days	Over 90 days
$118,321	$1,877,244
Over 120 days	Over 120 days
$8,988,492	$12,952,266

Staff Follow-up Response, January 1996

Based on information provided Program Review staff, questionable efforts for improvement have been made in this area.

RECOMMENDATION #11: Development of Utilization Guidelines and Criteria.

The Department for Medicaid Services should develop guidelines and criteria to define appropriate utilization to meet recipient needs and recognized standards of health care.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

No response necessary.

Staff Follow-up Response, January 1996

907 KAR 1:677E was filed December 5, 1995 to promulgate regulations to identify misutilization of Medicaid Services.

Recipients over-utilizing services can be placed on lock-in. The lock-in program requires the recipient to choose one physician and one pharmacy for services. However, there are loopholes that can inhibit the effectiveness of this alternative to managed health care. If the recipients or providers do not comply with the program, there are no penalties.

RECOMMENDATION #12: Freedom of Choice Waiver for Lock-in Recipients.

The Department for Medicaid Services should study the effectiveness of amending the state plan to request a wavier to restrict freedom of choice provisions. The restrictions would allow the Department to assign a recipient placed on lock-in to a Medicaid provider, in lieu of allowing the recipient to choose their lock-in provider.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

No Response necessary.

Staff Follow-up Response, January 1996

907 KAR 1:677, filed December 5, 1995, addressed the Medicaid recipient lock-in.

Kentucky established a Drug Use Review and Advisory Board (DURAB) effective January 1993. The program, established to comply with federal requirements, is to assure that prescriptions for outpatient drugs are appropriate, medically necessary and are not likely to result in adverse medical results. The DURAB has appointed a subcommittee to review quality drug therapy.

Five regional Drug Utilization Review boards review recipient usage. The Kentucky Drug Use Review Service has been in operation since February 1988. The Boards are composed of two private practice pharmacists and one private practice physician. A review is conducted in such a manner as to determine recipient usage and not physician or pharmacy dispensing patterns.

The Medicaid Abusable Drugs Audit System (MADAS) will analyze and identify patterns of high drug utilization. The DMS received the MADAS from the US Office of Inspector General this past year. At this time the Department is developing its plans on MADAS utilization and program implementation.

KenPAC drug utilization control relies on the participants, recipients and providers. The DMS established the criteria for drug pre-authorization. The Department has stated that the prior authorization program assists in controlling cost and drug abuse. However, it appears that the program has not been evaluated to determine the effectiveness in lowering costs or abuse.

For FY '93 EDS received 153,311 requests for drug pre-authorization. Ninety-three percent were approved.

Requested Reviews of the Kentucky Medical Assistance Program

In response to a request by the Program Review and Investigations Committee, the Auditor of Public Accounts conducted and contracted reviews of certain elements of the Medicaid Program. The Auditor of Public Accounts staff conducted reviews of the non-emergency medical transportation and provider enrollment process. In addition to staff reviews, the Auditor's Office contracted with Coopers and Lybrand for reviews and audits of the following areas: 1) review of the contract between Electronic Systems Data (EDS) and the Department of Medicaid Services; 2) an audit of the Medicaid Management Information System (MMIS); 3) an audit of the Medicaid Assessment Improvement Trust Fund (MAIT) and the Medical Assessment Revolving Trust Fund (MART). These reviews and audits are available for inspection in the Auditor of Public Accounts Office.

Reviews of Ancillary Services in Nursing Homes and Outpatient Hospital Services.

On April 1, 1992 a contract between CHR and Progressive Health was executed to review ancillary services in nursing homes and outpatient hospital services. The nursing homes and hospitals were chosen randomly from the Medicaid exception list. The list contained approximately 80 facilities, with a total of ten nursing homes and ten hospitals being randomly selected for review.

The reviews indicated approximately $840,000 in overcharges and other questionable costs associated with the randomly selected facilities.

On November 18, 1992, the office of Inspector General was requested by the General Counsel and the Commissioner of the Department of Law to review the subject matter of the Progressive Health Review. These reviews are available for inspection at the Human Resources Cabinet.

Program Review Follow-ups, Worksheet, and Agency Responses in Appendix

The December 1994 and December 1995 Program Review follow-ups to the September 1993 study appear in the Appendix.

A recommendation worksheet also is listed in the Appendix, along with the Cabinet for Human Resources responses to findings and recommendations presented to the Program Review and Investigations Committee.

CHAPTER I

INTRODUCTION

The Kentucky Medical Care Program, a forerunner of the Medicaid program, was established in 1961 to provide limited services, such as inpatient hospital services, physician services, dental services, and pharmaceuticals, to low-income citizens. In 1966, the Kentucky Medical Assistance Program (KMAP) was established to implement the federal Medicaid law (Title XIX). The implementation of this law led to an expansion in both clients served and services offered.

KMAP implemented the Medicaid Management Information System (MMIS) in 1981. MMIS is an automated claims reporting system. In addition to processing claims, the system also is designed to generate utilization and management reports. In 1983, the claims processing function was transferred to a Medicaid fiscal agent, Electronic Data Systems (EDS). The state retained responsibility for the other areas of the Medicaid program, including program benefits, policy, quality control, and surveillance utilization review. In 1986, the Department for Medicaid Services (DMS) was created, with the designation that it was to be the single state agency with responsibility for the Medicaid program in Kentucky. DMS currently has four divisions: Program Development and Budget, Patient Access and Assessment, Reimbursement and Operations, and Program Services.

Statistical Information

The Kentucky Medical Assistance Program accounts for a large share of the state's expenditures, especially in the area of federal funds. Chart 1 shows the amount of Medicaid funds as a percentage of different state funds. For FY 1993 -1994, the state share of the Medicaid match, $468.1 million, accounts for 9.6% of total General Fund expenditures. Total spending on Medicaid accounts for 22% of the state's total operating budget. Additionally, the $1.8 billion federal share of the Medicaid program represents just over 48% of all federal funds coming into the state this fiscal year. The $1.9 billion spent on the Medicaid program in FY 1993-94 will provide services for a projected 520,979 eligible recipients. Not all eligible recipients, however, utilize Medicaid services. In FY 1992, for example, only 291,851 (61.7%) of the 473,286 eligible recipients received any type of Medicaid services. (Chart 2)

Methodology

In pursuing the objectives of the present study, Program Review staff employed several methodologies. Initially, all employees of the central office of DMS were surveyed regarding their impressions of the present operation and management of the department. Staff also conducted interviews with staff of DMS, along with the Medicaid fiscal agent, Electronic Data Systems, and the Department of Social Insurance, which has responsibility for determining eligibility for the program. Staff reviewed the Code of Federal Regulations (CFR), Kentucky statutes and regulations, and the state Medicaid plan, to determine compliance and responsibility. Documents reviewed by the staff included Surveillance/Utilization Review System (SURS) reports, Drug Utilization

CHART 1

G: Medicaid\bchrts.xls

CHART 2

G: Medicaid\bchrts.xls

Review System (DURS) reports, financial documents concerning payments to and recoupments from providers, third party liabilities, and other fiscal operations of the program.

Potential Annual Savings or Recoveries of Medicaid Funds

Documents reviewed by Program Review staff revealed potential annual savings or recoveries of funds that range from $170 million to $211 million.

Chart 3 lists potential savings as they relate to recommendations approved by the Program Review and Investigations Committee. The potential savings do not include recipient overpayments. A Department of Medicaid Services staff member indicated that no recipient overpayments had been pursued since a department reorganization occurred in 1989. This staff member stated "for reasons unbeknownst to staff, the Medicaid recovery process was eliminated when we reorganized in the Fall of 1989."

CHART 3

Program Review and Investigations Committee

Potential Annual Savings or Recoveries of Medicaid Funds

RECOMMENDATION	POTENTIAL SAVINGS
Rec #1: KenPAC should be evaluated	**$5,000,000 - $10,700,000**
Rec #4: DSI Eligibility Audit	**$3,000,000 - $4,000,000**
Rec #10: PURSUING OVERPAYMENTS AND TPLs	
Provider Overpayments Accts Rec	**$6,250,000****
SURS Accounts Receivable	**$1,464,000****
Third Party Liabilities Accts. Rec	**$83,265,000****
Implement TPL Resource Collection	**$2,000,000***
Provider Overpayments RE: Appeals	**$3,921,000****
Review Cost-based and Other Reimbursement System	**$50,000,000-$75,000,000***
Rec #11 UTILIZATION GUIDELINES AND CRITERIA	
Selective Contracting for High Tech Services	**$500,000***
Redefine Control and Use of Hospital Service	**$5,000,000 - $7,000,000***
Restructure Emergency and Non-emergency Transportation	**$1,000,000***
Implement On Line Point of Sale Drug Utilization Review	**$3,000,000 - $5,000,000***
Acquire State of the Art Technology for Fraud and Abuse Detection	**$1,000,000***
Implement System to Enhance Program Integrity	**$5,000,000 - $10,000,000***
TOTAL	**$170,400,000 - $211,100,000**

NOTE: Savings do not include recipeint recoveries since 1989

*Based upon CHR estimates

**Based upon identified balances

CHAPTER II

STATE PLAN

The State Plan is a comprehensive written statement submitted by the Department of Medicaid Services (DMS) describing the nature and scope of its Medicaid program and offering assurance that it will be administered in conformity with the specific requirements of Title XIX and other applicable official issuances of the federal Department for Health and Human Services. The State Plan contains all information necessary for the federal Health Care Finance Authority (HCFA) to determine whether the plan can be approved to serve as a basis for federal financial participation. In addition to material that covers basic requirements, the plan also contains individualized material that reflects the characteristics of the state's program.

The plan must provide that the Governor or his designee will be given a specific period of time to review long-range program planning projections and other periodic reports. To effectively implement the state's program, the state must begin planning well in advance of submitting the plan. Innovative techniques must be explored and evaluated to increase efficiency of the programmatic and administrative areas.

Plan Amendments

The plan must provide that it will be amended whenever necessary to reflect changes in federal law, regulations, policy interpretations, court decisions, material changes in state law, organization, policy, or the state's operation of the Medicaid program. As the program operates, state officials may recognize areas that require change in order to expedite needed services to Medicaid recipients or to avoid abusive or wasteful practices of providers and recipients.

Amendments must be submitted to HCFA for its approval. The state must submit documentation detailing why an amendment is necessary. The amendment will be considered approved unless HCFA, within 90 days after receipt of the amendment in the regional office, sends the state written notice of disapproval or notifies the state that additional information is needed.

Waivers--A Management Tool

Waivers are intended to provide the flexibility to enable states to try new or different approaches to improve the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of recipients. Waivers allow exceptions to State Plan requirements (federal mandates), and permit a state to implement innovative programs or activities on a time-limited basis, subject to specific safeguards for the protection of recipients and the program. By requesting carefully designed waivers, states can design techniques that result in increased efficiency and services that reflect the needs of the recipients, thus increasing planning capabilities. To achieve desired results, program managers and planners must

continue to monitor program activity on a regular basis, to insure that implementation complements the waiver.

KenPAC Waiver Program

One example of a waiver program in Kentucky is the Kentucky Patient Access and Care Program (KenPAC). KenPAC began operating in 1986 and was intended to provide AFDC recipients and AFDC-related populations with managed health care. The program goals were to insure needed access to health care, provide continuity of care, prevent unnecessary utilization and costs, and strengthen the patient and physician relationship. Today, the program is available in 112 counties; 305,000 recipients are assigned to KenPAC providers.

Cost Saving Estimates Vary

Several estimates have been made on the cost savings of KenPAC to the Medicaid Program. No clear or concrete answers have been derived. In information provided to the General Assembly in June 1993, the Department of Medicaid Services reported cost savings of $125,000,000 for FY '92 and estimated the same cost savings for FY '93 and FY '94. The report indicated a huge increase in cost savings from FY '90 of approximately $50,000,000 to $125,000,000 in FY '91. This information was provided by the KenPAC Branch of Patient Access and Assessment. Program Review staff could not determine whether the Department based its estimate upon the report conducted by the University of Kentucky, nor the reason for the large savings increase in FY '91.

A GAO report, Kentucky's Managed Fee For Service Program, discussed the KenPAC program. The report cited Kentucky's 1991 waiver renewal

request, in which officials estimated that KenPAC might save $93,000,000 in 1994. The GAO report also cited the UK study that estimated the savings at $125,000,000 to $150,000,000 per year. GAO reviews indicate that the difference is based on the number of recipients estimated to participate in the program. UK assumed a greater number of participants, which allowed for a potentially larger savings.

The University of Kentucky School of Allied Health completed a program evaluation of KenPAC in November 1992. This study attempted to predict the cost savings KenPAC might realize for the Medicaid Program. The study used three models to predict cost savings from the time period of 1991 to 1993. The predicted savings for the three-year period ranged from $468,475,178 to $1,649,853,187.

The University of Kentucky's models included some program assumptions. UK assumed there would be no program changes, nor recipient population increases, and its cost data were deflated, using CPI from 1985 to 1991, with no cost increase in prices for the three years. Also, the models assumed that the program is effective, and that an efficiently managed health care program would lower patient utilization of services.

UK Study Identifies Utilization Problems in KenPAC

In studies conducted by the Martin School of Public Administration at the University of Kentucky, it was reported that physicians participating in the KenPAC program felt that the program had a positive impact on health care. These reports did note some problems with patient education and recipient overutilization. KenPAC recipients can misutilize program services. While

KenPAC physicians should teach recipients about proper program utilization, the program places responsibility upon the recipient to appropriately utilize services. A UK survey reported a consensus among physicians and emergency room staff that most KenPAC recipients have little understanding of KenPAC procedures. Physicians responded that 45.6% of recipients have little or no understanding of KenPAC procedures, with 45% having a moderate understanding. Emergency room staff responded that 73% have little or no understanding and that 25% have a moderate understanding of KenPAC procedures. The problems of emergency room overutilization and recipients' lack of program understanding would appear to raise some concerns regarding the effectiveness of the program.

Overutilization of emergency room treatment was a primary area of concern. This overutilization was attributed to difficulties in contacting and receiving approval for treatment from the attending KenPAC physician and the uncertainty of liability if treatment was refused.

The concern of emergency room overutilization was also noted in a study conducted by the Kentucky School of Allied Health. In that report, recipients, physicians, and emergency room staff were surveyed regarding emergency room utilization. Thirty-three percent of the responding recipients stated that they visited an emergency room in the past sixty days. Forty-two percent had visited an emergency room for a child's treatment. Physicians responded throughout the survey that abuse of emergency room care continued. Emergency room staff responding to the survey indicated that in the past six months, 16,665 KenPAC visits had been recorded. In the open-ended question and comment section, emergency room staff indicated that being unable to reach KenPAC primary care physicians and failure of KenPAC physicians to

appropriately respond to the authorization request were problems. Several responses indicated that the physicians were concerned over the liability of refusing treatment and therefore approved it, or left the determination to emergency room staff.

Waiver Renewal Pending

The wavier renewal application was due in October 1994. Department recommendations to the Subcommittee on Finance and Medicaid Review included the following: increasing the Medicaid population eligible for KenPAC enrollment; implementing financial incentives for KenPAC physicians who effectively manage the care of their patients (estimated increases are raising the management fee from $3 per patient per month to $5 per patient per month); establishing an oversight and education component to help educate recipients regarding the appropriate and effective use of the system; and establishing a system to prevent duplication of the provision of ESPDT-type services to children in the KenPAC program.

In the information provided to the General Assembly in June 1993, the Department listed 305,000 recipients enrolled in KenPAC. The Management and Administrative Reporting Subsystem reported that for FY '92, 61.7% (or 291,851) of the total Medicaid population utilized services. Approximately 60% of the total Medicaid population is enrolled in KenPAC. If all 291,851 Medicaid recipients were in KenPAC, then there would still be approximately 13,000 KenPAC recipients who did not utilize services. However, the KenPAC physicians received the monthly management fee even if the recipients did not utilize their services.

RECOMMENDATION #1: KenPAC Should Be Evaluated

The Cabinet for Human Resources should require an independent evaluation of the effectiveness of the KenPAC program. The program should be redesigned to address any deficiencies in cost containment, service utilization, program education, program availability or management fees. The evaluation should be completed before the wavier renewal application is submitted to the federal Department of Health and Human Services.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

In our earlier reports to the Program Review and Investigations Committee, we have indicated that the KenPAC "gatekeeper" concept would be evaluated in conjunction with the required evaluation for Section 1115 Health Care Partnership Waiver. Because we expect KenPAC to be replaced by this larger initiative, we believe this strategy represents the most economical use of scarce resources. However, because the HCFA approval for the Section 1115 waiver was delayed until October 6, 1995, the evaluation of this waiver also has been delayed. Such evaluation will not, in all likelihood, begin until on or after July 1, 1996. For your information, a copy of a recent resolution was adopted by the Kentucky Medical Association in support of the KenPAC Program.

Staff Follow-up Response, January 1996

In 1989 and 1991, studies conducted by the Martin School of Public Administration at the University of Kentucky reported that physicians participating in the KenPAC Program had concluded that the program had a

positive impact on health care. The report did note some problems with patient education and recipient over-utilization. Physicians who choose to participate in the program should inform the recipients regarding proper program utilizations, although the program places responsibility upon the recipient to appropriately utilize services. A UK survey reported a consensus among physicians and emergency room staff that most KenPAC recipients have little understanding of KenPAC procedures.

Over-utilization of emergency room treatment was a primary area of concern. Over-utilization was attributed to difficulties in contacting and receiving approval for treatment from the attending KenPAC physician and the uncertainty of liability if treatment was refused.

The Auditor of Public Accounts' Statewide Single Audit for the year ending June 30, 1994, noted problems with the internal control procedures of the KenPAC waiver program. The Auditor's office recommended that DMS increase the amount of monitoring activity. The audit revealed concerns with the procedures the DMS uses to add new providers or update its provider listings. The single audit also cites concerns with the trend report used to review utilization, indicating that KenPAC did not consistently notify providers of unacceptable scores nor place providers on probation, as required in the waiver. The report stated that "a strong internal control structure requires procedures be in place and fully utilized to ensure compliance with the waiver agreement."

In August 1994, the CHR's Inspector General stated in a follow-up study of outpatient services that "over utilization of the emergency room by KenPAC patients indicated a weakness in the program since physicians should be involved with case management of these individuals."

CHAPTER III

FISCAL ACCOUNTABILITY

A preliminary examination of the Department of Medicaid Services (DMS) fiscal practices revealed a lack of written policies and procedures and questionable practices in the areas of advance payments, discharges, retaining provider checks and declaring hardship. In addition, a need for expanded or continued auditing was identified in Kentucky's Medicaid Management Information System (MMIS), Medicaid Trusts, and DMS interagency agreement with the Department of Social Insurance (DSI).

Need for Auditing Select Activities

Under federal regulations, states can establish management information systems to process claims, retrieve and produce service utilitilization and management information for state and federal governments. The information is to be used for program administration and audit purposes. (42 CFR 433.111) Kentucky's MMIS was implemented in 1981, and in 1983, a fiscal agent, Electronic Data Systems (EDS), was acquired to do claims processing. However, concerns have been raised about the effectiveness of the MMIS. Because of these concerns, the Auditor of Public Accounts was requested to perform an audit of the Claims Cycle of the Medicaid Management Information

System by the Program Review and Investigations Committee. A copy of this report is available in the Office of Auditor of Public Accounts.

Kentucky's Management Information System Needs In-Depth Audit

Financial reports received from EDS conflicted with each other. Reports for the same period (a fiscal year) may differ depending on the way the data are requested. For example, financial data requested using transaction codes (payout, accounts receivable, refund, recoupment, manual check), which EDS states are more accurate, produce one total. Data requested by reason codes, which are used for informational purposes only, produce another total. Also, the totals for reports by reason code do not match those of status reports. Some reasons cited by DMS for the imbalances are:

- data entry or clerical errors, e.g., on a payout report for FY 1993, the amount of $99, 046.00 was incorrectly coded as a payout when it was a recoupment;
- transactions changing from one type to another, e.g., an overpayment is set up as a refund, but the provider does not pay, so the transaction is changed to a recoupment. Changes may appear on one report and not another; and
- ad hoc reports may not reflect forced closes, cancellations or reductions in the original amount of the overpayment, while a status

report would show the effect of such a change on recoupments.

When Program Review staff requested reports by reason code, another problem was found. According to the code descriptions provided by EDS, reason code 036 (Payout -Other) is not used. However, payout reports for fiscal years 1992 and 1993 showed over $2.1 million and over $477 thousand, respectively, coded to reason code 036. EDS explained in a written response that "The reason code definition list incorrectly stated that code 036 is used to identify DMS requested payouts which are not related to a cost settlement."

DMS is responsible for monitoring the system and approving codes. A DMS official said that the current system has been in existence since 1983 and has basically remained the same. Revisions have been made for such requirements as third party liability (TPL), but the system has not been revised overall.

According to 42 CFR 433.111, the Mechanized Claims Processing System serves a dual purpose, program administration and audit function. With the current system, difficulties exist in procuring accurate information. Balances in the MMIS system apparently do not reflect information in the DMS files. On September 10, 1993, EDS was contacted concerning the balance of an account for a provider who had sold the facility in 1991. Program Review staff was searching for a discharge of $89,268 that had occurred in August 1992. The system did not reflect this discharge.

Reviews previously completed by the Auditor of Public Accounts, and Deloitte and Touche in November 1992, and Coopers and Lybrand in September 1993 indicate a need for a financial and management audit of the entire system.

Additionally, the Report of the Statewide Single Audit, prepared by the Auditor of Public Accounts, has indicated (June 30, 1992) that weaknesses exist in the internal controls of the drug rebate program for DMS and EDS. The report further states that irregularities could occur and never be detected or corrected.

RECOMMENDATION #2: MMIS Audit

A private and independent audit of the MMIS system should be commissioned immediately by the Cabinet for Human Resources.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The responsibility for the Medicaid Management Information System (MMIS) was transferred to a new fiscal agent, UNISYS, on December 1, 1995. Because the Coopers and Lybrand review, completed on March 11, 1994, found very few and minor exceptions with the EDS operated MMIS and because EDS is no longer the fiscal intermediary for Medicaid, we would like to defer our report on the actions taken by the agency to address the Coopers and Lybrand findings until such time as the UNISYS system is more stabilized and our response can be expressed in a UNISYS context.

Staff Follow-up Response, January 1996

A contract with Coopers and Lybrand was initiated and the report was issued on March 11, 1995. The report identified potential savings of up to $209 million in the following three areas: utilization control, enhanced accountability and improved efficiency.

Medicaid Trusts Need Auditing

Under the Hospital Indigent Care Assurance Program (HICAP), which ended on July 1,1993, two trust funds were created: MAIT (Medicaid Assessment Improvement Trust) and MART (Medicaid Assessment Revolving Trust). The MART account consists of funds collected from hospitals and other participating providers. The MAIT fund consists of funds transferred from the MART account and is designed to meet contingencies of the Medicaid program. KRS 205.577 requires DMS to conduct annual audits of MART to ensure that amounts paid to providers are correct. Likewise, KRS 205.590 requires that prior to authorizing any expenditures or any transfer of MAIT funds for CHR administrative expenses, there must be legislative and executive review.

According to the former Commissioner of the Medicaid program, in a memorandum dated July 9, 1993, the single state audit performed by the State Auditor's Office was to address these two trust funds. Only the expenditure side of this audit was performed. According to information from the State Auditor's Office:

> Transactions relating to these accounts were included in an overall population. Specific documents from these funds may or may not have been selected in the samples tested, but an extensive review of these trusts was not performed in the prior year audit.

No complete audit of the trust funds has been performed. The State Auditor's Office confirmed that, at the request of CHR, the contract with Coopers & Lybrand to audit the HICAP program, from its inception, has been amended to include these two trusts. The deadline for completion of this audit was December 15, 1993.

RECOMMENDATION #3 : Trust Fund Audit

The Cabinet for Human Resources should audit of the two funds on a regular basis, and in compliance with state statutes. The State Auditor's Office should provide copies of its audit to the Interim Joint Committees on Appropriations and Revenue and Health and Welfare Committee, and the Program Review and Investigations Committee.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

No response required.

Staff Follow-up Response, January 1996

No response necessary.

DSI Eligibility Determination Audit

The Department of Social Insurance (DSI) provides eligibility determination services under a $15 million interagency agreement or contract with DMS. DMS and DSI currently operate the Medicaid eligibility determination and related programs without a signed contract. The FY 1992-93 contract expired on June 30, 1993. The contract is subject to renewal and cancellation, but there is no provision for continuation. This is not a situation unique to this year; previous contracts have been late as well. A DMS official predicted that the new contract, estimated to be approximately $15.2 million, should be ready for signatures by mid-September.

The contract for FY 1992-93 states that DMS should:

> Complete a case review two(2) times per year of AFDC related Medical Assistance and Aged, Blind and Disabled cases to determine if Medicaid program policy is being correctly interpreted and applied. (Section II. G)

According to a DMS official, DMS has never complied with this clause, although it has been part of the contract for at least two years. The reason cited was lack of staff. Therefore, DMS has not performed its audit function to evaluate policy interpretation and eligibility criteria decisions being made by the contracting agency, DSI.

RECOMMENDATION #4: DSI Eligibility Determination Audit

The Cabinet for Human Resources should expedite the signing of the FY 1992-93 Interagency Agreement and perform internal monitoring of the contract by auditing policy interpretation and criteria for eligibility determination and related programs.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The Division of Program Development and Budget monitors the implementation of the eligibility contract. Staff in the Policy Analysis and Eligibility Branch review all proposed eligibility manual material prior to its use by DSI field staff to ensure conformity with policy. In addition, the Branch reviews for consistency with agency policy, all policy clarifications the Department for Social Insurance (DIS) central office staff provide to local office field staff on individual issues. Branch staff also receive and process eligibility related inquiries from the Office of the Ombudsman, members of the General Assembly, applicants and recipients, and members of the general public. A

member of the Branch is also the Medicaid liaison with the Department for Social Insurance with regard to the Kentucky Automated Management and Eligibility System (KAMES) and ensures that the KAMES computer system is consistent with and accurately reflects eligibility policy as set forth by the Department for Medicaid Services. The Branch and other staff also monitor the audits of the federal Medicaid Eligibility Quality Control (MEQC) system. The amount paid under this contract to DSI is $23,592,900 for FY 95-96.

Staff Follow-up Response, January 1996

The interagency agreement between the DMS and the DSI to perform recipient eligibility processes is currently $23.5 million. This is an $8.5 million increase since 1993. The initial study by Program Review in 1993 found the DMS had never reviewed cases completed under the interagency agreement with the DSI. The Program Review recommendation urged the DMS to review case files to ensure policies were interpreted and applied correctly.

Coopers and Lybrand recommended that the DMS-DSI Interagency Agreement be restructured to include a fixed reimbursement method, performance standards and a higher level of accountability.

Necessity for Policies and Procedures

A lack of written policies and procedures in several areas raises questions about the level of discretion used to make decisions in the areas of advance payments, discharges, and hardship. Also, questions arise about the consistency with which these activities are conducted and accountability

measures. The practice of retaining provider checks for extended periods is also a concern.

Payouts and Advances

DMS makes two types of payouts: true payouts and advances (also called advance or interim payments.) According to DMS, a true payout is "money paid to the provider that will not be returned by refund or recoupment." True payouts are made when a provider is due money because of billing errors, costs settlement or rate adjustment processes, or reimbursements for purchasing medical equipment for recipients. A review of automated payout records for fiscal years 1991-1993 shows that over $28.0 million in payouts were made for errors on refunds, costs settlements, and other reasons not specifically identified. (Additional payouts were made via manual checks.) In addition, records for medical equipment reveal that over $100 thousand has been paid out for medical equipment (e.g., customized wheelchairs, dynasplints, and adaptive communication devices) purchased for recipients.

Providers Are Advanced Funds

An advance payment is "money paid to a provider that will be returned through refund or recoupment". Advance payments are made when a provider asserts that conditions exist that will create financial problems (e.g., inability to meet payroll, cash flow problems, several claims in suspense) which could endanger the continuation of services to clients. The DMS says the following circumstances could necessitate advances: 1) system changes, e.g., a new mandated claim form that causes a delay in the usual claims processing schedule, 2) a new or drastically revised benefit program with services covered

and provided prior to completion of the claims processing system, and 3) recoupment of mass adjustments applied in successive cycles, causing provider cash flow problems. Under these circumstances, a provider may receive an advance payment of up to 75 percent of the pending claims found on the provider summary screen. If no claims are pending, "the previous month or prior year average monthly amount is used to calculate the amount paid."

In addition, a new provider who experiences a delay in payments may receive an advance payment. The amount of the payment is based on the number of clients being served, the types of services provided, and the number of days services that have been provided. The DMS cited a change in the AIS/MR Waiver as an example. In 1988, the AIS/MR Waiver program was changed by federal mandate, and involved new small providers that had been previously employed by Community Mental Health Centers (CMHCs). Federal mandates required providers of AIS/MR services to be billed separately. This caused new small providers to be brought into a system that was not ready to process claims. Advance payments were necessary to continue services to clients, and new providers received advances against their paper claims. According to DMS, advance payments are usually recouped in the next payment cycle, but may be repaid in installments.

Number of Advance Payments Is Unclear

A review of automated and manual check records shows that many advance payments are made through the manual process. The data, however, may be misleading, as financial transactions listed under computer code 035-Payout-Cost Settlement could include advance payments to providers according to EDS code descriptions. In addition, data on the types of transactions placed

in a "Payout-Other" category is not available at this time. A system report of payouts shows only one advance payment code for the three fiscal years previously cited. On the other hand, six manual checks were written for advance payments during the six-month period in 1993. A DMS official said that advance payments are made using the manual process because it is quicker.

Authority for Advance Payments Is Questionable

According to DMS officials, there is no statutory or regulatory authority to make advance payouts. However, their official response states that "OAG 82-281 provides for advance payments if there is sufficient documentation that the services for which payment is made have been rendered." According to OAG 82-281, services for the state have to be performed prior to receiving payments in order to meet constitutional and case law requirements. However, the Attorney General's Opinion states that when it is contemplated that "state money must be turned over or advanced to private or corporate contractors before contractual services are actually rendered," and the state official contracting for the services determines in good faith that such advances are necessary, they may be constitutional under two conditions. First, the contract must expressly state that the responsible contractor will not make final disbursement of the advanced funds until the services have been rendered. Second, to protect the state treasury, the contractor must execute a suitable bond or get an insurance contract providing for the full repayment to the state where advanced money has been disbursed without indicating the type of contractual services to be rendered.

Provider agreements, which serve as contracts in most instances, state:

> 2. In consideration of approved services rendered to the Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with applicable federal and state laws, rules, regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services." (Home Health Services Manual: Kentucky Medicaid Program, Home Health Benefits, Policies and Procedures, n.d.)

If this is the case, it might be difficult to say that current practices meet the criteria set forth in OAG 82-281 for allowing advance payments. A loosely construed interpretation of the first sentence cited above might support the DMS's unofficial policy of making advances. The practice of making advance or interim payments to providers for pending claims seem to comply with the spirit of OAG 82-281, the practice of making payments to new providers may not. At this point it is not clear whether new provider advances are made only to new AIS/MR providers or to all new providers.

The DMS may not view the practice of making advances as a problem. Recoupments of advances are usually set up in the next payment cycle, or a repayment plan is arranged. Data on the manual checks written for advances show that three of the six advances had been recouped and the others were said to be in the process of recoupment. Data are not available on other advances at this time.

DMS Has Discharged Debts Owed by Provider

On August 10, 1992, the former Commissioner of Medicaid Services discharged an overpayment of $89,268 owed to the Department of Medicaid Services. This overpayment took place between September 1, 1990 and September 30, 1991. The letter notifying the provider of the discharge stated that the debt was being discharged for two reasons: 1) the overpayment was due to a clerical error during the rate setting process, and 2) repayment of the overcharge would place a financial burden on the provider. However, DMS staff clearly informed Program Review staff that there was not a clerical error. Additionally, it is unclear what the financial status of the facility was, since it was sold on September 30, 1991. According to CHR officials, after the discharge signed by the Commissioner was finalized, the funds could not be recovered or applied to future settlements.

RECOMMENDATION #5: Policies and Procedures Governing Forgiveness of Debts

The Cabinet for Human Resources should develop policies and procedures governing forgiveness of debts owed the Medicaid program. These policies should address criteria for determining financial hardship and provider disclosure information, and should ensure compliance with federal and state laws. A single authority within the Department for Medicaid Services should be designated for reviewing and approving these exceptional practices and should ensure proper monitoring and tracking within the MMIS.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The CHR has no procedures in place, as such, to "forgive" debts owed to Medicaid. The Cabinet does make every effort to collect on debts determined to be owed to DMS after the appropriate appeal process has been followed. On some occasions, the DMS, with advice from Counsel, had determined that settlement agreements may be appropriate and in the best interest of DMS, in order to collect at least the federal share. The federal portion of the match continues to be approximately 70 percent. The Department will not consider any offer for a settlement unless the provider's offer includes an amount greater than or equal to the federal share amount. No settlement agreement is final without consultation between the Department of Medicaid Services and the Office of the Counsel.

Staff Follow-up Response, January 1996

The CHR should develop policies and procedures to ensure consistent actions and actions that ensure the state's interest is in place when lesser amounts are accepted in settlements. Settlement agreements to collect "at least" the federal share may not be in the state's best interest. Criteria should be established which ensure that federal and state interests are protected.

RECOMMENDATION #6: Review the Legality and Necessity for Making Advances and Discharges

The Cabinet for Human Resources should determine the legality of making advance payments and discharging overpayments. If the Cabinet determines there is a legal authority to continue these practices, it should formalize the processes by developing regulations that will specify when,

how, and to whom advances and discharges should be made. In addition, regulations should specify a central authority for authorizing advances and discharges, describe measures for tracking and monitoring the claims involved, and insure that these transaction are appropriately recorded and reflected in the management information system in a manner that will allow easy retrieval.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

There are no regulations that address the authority for Medicaid to make advance payments. Interim payments are only issued when it is deemed necessary to prevent the interruption of services provided to Medicaid recipients. Whenever payout is required, a payout authorization form must be completed and signed by a Division Director and the Deputy Commissioner or Commissioner of Medicaid Services.

A report of the providers who were issued advance payments in 1995 has been provided.

Effective December 1, 1995, Medicaid changed its fiscal agent from EDS to UNISYS. UNISYS has been unable to process claims correctly for payment for some provider types; therefore, Medicaid has issued interim payments to virtually all providers, based upon pending claims or provider certifications of services provided to Medicaid recipients. These interim payments are not included in the enclosed report. Reconciliations through the new claims processing system will be made when edits and audits are appropriately in place.

Staff Follow-up Response, January 1996

The CHR should develop policies that comply with OAG 82.281 for allowing advance or interim payments. Development of this policy appears more important today than ever before, with the DMS's situation involving the transition of a new fiscal agent and the use of interim payments.

Hardship

Provider hardship, and how it will be determined, is an issue when making decisions to advance payments to providers and when payment plans are requested to pay back overpayments. While federal regulations and 907 KAR 1:110 offer some guidance on criteria and methods for handling cases of exceptional hardship, e.g., bankruptcy, criteria for determining general hardship are vague.

Hardship Criteria Are Not Clearly Defined

No formal criteria exist regarding what constitutes financial distress or hardship in order to qualify for an advance or interim payment. Previously, providers could telephone DMS and request an advance. Within the past six months, DMS has started requiring providers to send in a letter stating their need. Prior to this, the primary means of verifying need has been a review of provider history and the amount of claims pending.

While a DMS official indicated that advances are usually made to new providers under special circumstances, e.g., the AIS/MR program, the information provided to the Program Review staff does not make that distinction

clear. The DMS response reads as though the DMS can provide what amounts to an interest-free short-term loan to new providers.

A recent administrative regulation, 907 KAR 1:110, which specifies provisions for recouping overpayments, does not specify how hardship is to be documented or verified. According to the regulation, providers that can demonstrate making a full payment would cause an undue hardship may request a payment plan. Interviews with DMS officials in the Division of Reimbursement Operations and SURS Branch revealed that there are no guidelines for determining hardship. In a 1992 memorandum, the Director of Reimbursement Operations stated that "Providers will need to provide some type of documentation, in writing, in order to demonstrate this hardship; telephone calls and a simple statement will not suffice." Without guidelines, the Director says reasonable standards are used. Providers have to send in bank statements and a financial statement, and DMS staff review a claims paid listing when determining hardship. DMS staff try to look at the percent Medicaid is of total income, and the amount that Medicaid pays monthly. DMS will usually start with a six-month plan to repay funds. If, however, Medicaid payments are high enough in relation to the requested amount, the payment plan may be reduced to 3 months. Sometimes providers will call other DMS officials and payment plans will be changed.

In the SURS Branch, there are no formal procedures for determining hardship. The Director of the division felt that when a provider claims hardship, one should look at the share of total income that Medicaid payments comprise, and the amount of the refund being requested. A DMS official was asked what happens if DMS cannot collect. The response was that they send

documentation to EDS stating the reasons they cannot recover the money, e.g., the provider has moved out of the country, or the provider is deceased.

In cases of exceptional hardship, e.g., bankruptcy or the dissolution of the provider entity, SURS usually gets a copy of the bankruptcy petition from the provider's attorney. Generally, cases of bankruptcy are sent to the Department of Law, so that it can determine whether DMS should file a claim against the debtor.

RECOMMENDATION #7: Develop Policies for Hardship Requests

The Cabinet for Human Resources should develop policies to define hardship. In addition, policies and procedures should specify a central authority for authorizing hardship, types of documentation required to prove hardship, timeframes for submitting the documentation, appeal rights, and methods that will be used to verify provider documentation.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

A copy of 907 KAR 1:671 (see page 18 of the regulation), which covers this issue, has been provided.

A report of all providers who received approval for payment plans in 1995 has been provided.

Staff Follow-up Response, January 1996

Policies were adopted in June 1995 which should provide consistent implementation.

Retention of Provider Checks

DMS currently retains certain checks in its office. These checks represent payments to providers which have not been issued because problems have arisen. According to DMS, these funds are held in a safe for four different reasons:

1. Cost reports of facilities are overdue.
2. The ownership of the provider has changed.
3. DMS is waiting for final review of the close of business cost report.
4. DMS has terminated the provider's participation in the program, and checks are being held pending outstanding claims.

Checks Have Been Held for Up to 11 Months

The amounts of the checks and the time periods for which they have been held vary. For example, in a January 1993 "escrow" report, a small check was listed as being held for over 11 months. In another example, the escrow report for February 8, 1993, showed a check for over $37,000 which was dated October 13, 1992. In the middle of January 1993, the total amount of the checks being held was $1,519,900. As of August 16, 1993, the total being held was $105,978.

This process obligates state and federal funds which could be used for other payments. It seems that a more efficient practice would be for DMS to wait for a resolution of the problem prior to cutting the checks. If the check has been cut before the problem is discovered, the check should be canceled and reissued after the matter is resolved.

RECOMMENDATION #8: Need for Policy and Procedures on Check Retention

The Department of Medicaid Services should develop policies and procedures that reflect applicable state and federal policies on check retention.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The regulation regarding the withholding of payments has been provided as Enclosure 4 (see section 8 of the regulation). A report of escrow activity as of November 30, 1995, has been provided as Enclosure 6. The dollar amounts will be forwarded as soon as it is available from the UNISYS system.

Staff Follow-up Response, January 1996

The Medicaid study revealed the DMS practice of retaining checks for providers whose account activity was questionable. Program Review questioned the need to obligate state and federal funds by retaining uncashed/unissued checks or escrowing funds. As CFR 433.40 (c) provides, "If a check remains uncashed beyond a period of 180 days from the date it was issued; i.e., the date of the check, it will no longer be regarded as an allowable program expenditure."

The 1993 Medicaid study identified checks being held for 11 months. The PW escrow provider report of December 19, 1995, cited 35 checks and/or funds being held since 1994. No dollar amounts were available because the fiscal agent was unable to retrieve this data.

Disclosures of Ownership Interest

Disclosures of ownership and control are required to ensure the integrity of the Medicaid program. Some of the purposes include: identifying persons who have ownership in more than one provider, determining changes of ownership in sale of businesses, and making determinations in hardship and provider appeals.

Disclosures Are Required by Federal Law

Federal law requires most Medicaid providers and fiscal agents to disclose the identity of any individuals with direct or indirect ownership greater than five percent. Individual practitioners and groups of practitioners are excluded. Ownership includes equity in capital, stock or profits. These disclosures must include subcontractors. The following information must be disclosed:

- Name and address of each person;
- Relationship to another owner as a spouse, parent, child or sibling; and
- Name of any other provider in which the individual has an ownership or control interest.

The state Medicaid plan must require providers and fiscal agents to comply with these disclosure provisions. Provider agreements must require disclosure. Disclosures are also required when facilities are certified and recertified. The disclosing entity must request this information in writing from the person and must keep copies of all requests and responses, must make these requests available to the Secretary or the Medicaid agency upon request, and must advise the Medicaid agency when there is no response to the request.

Medicaid agencies should not approve and must terminate existing agreements if disclosures are not made. Federal financial participation is not available in payments to providers or fiscal agents that fail to disclose.

Disclosures Are Not Always Available or Current

Currently, the Division Of Licensing and Regulation of the Office of Inspector General collects ownership information on providers it surveys and certifies for participation in the Medicaid program. These disclosures are for facilities such as hospitals and nursing facilities. Program review staff reviewed these disclosures. A significant number were found to be inadequate because no information was given or the information was incomplete.

In response to requests from Program Review Staff, the DMS designed new forms for disclosures and is in the process of procuring the information from the applicable providers. According to a memorandum dated June 3, 1993, the Department must collect disclosure information from the following types of providers: durable medical equipment vendors, pharmacies, primary treatment facilities, ambulances, taxis, Comprehensive Mental Health Centers, Primary Care Centers, adult Day Health Centers, Alternative Intermediate Services/Mental Retardation (AIS/MR) and out-of-state providers.

RECOMMENDATION 9: Insure Collection of Disclosures

The Cabinet for Human Resources should insure that disclosures are obtained from all provider types and kept current.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

The Department of Medicaid Services has taken the initial steps in its effort to gather information from Medicaid providers relative to the disclosure of ownership. The disclosure form has been developed but the distribution and required completion of the form has been delayed until full implementation of the UNISYS claims processing mechanism has been placed in motion. The Department for Medicaid Services plans to go forward with the disclosure project as soon as the UNISYS takeover has been completed.

Staff Follow-up Response, January 1995

Disclosure of ownership and control are required by federal law to ensure the integrity of the Medicaid Program.

Although the need for the DMS to collect and analyze disclosure information should be paramount, the response from the Department indicates it has only taken the "initial steps in its effort."

CHAPTER IV

FINANCIAL RECOVERY

A preliminary look at recovery of Medicaid overpayments from recipients and providers revealed that little has been done over the last three years in the way of recovering recipient overpayments, especially those below $1,000. Over six million dollars in provider overpayments remain unpaid.

Another form of recovery involves third party liabilities (TPLs). TPL accounts are established when services paid for by Medicaid are the responsibility of other parties or insurers. Since Medicaid is designed to be the payer of last resort, the state pursues TPLs, once they are identified, by denying payment when the recipient has insurance coverage and by attempting to recoup payments made for services from liable third parties. It appears that more can be done to enhance TPL recoveries.

Recipient Overpayments

Recipients may receive erroneous benefits (overpayments) because of administrative error, client error or fraud and abuse. The Department of Social Insurance (DSI) Field Operations Manual states that suspected cases of Medical Assistance fraud should be referred to the Cabinet for Human Resources, Office of the Inspector General.

DMS Has Not Recovered Recipient Overpayments Since 1989

In 1989, a reorganization of the Department of Medicaid Services (DMS) led to the elimination of the division responsible for collecting recipient overpayments. According to a memorandum from the Director of the Division of Program Development and Budget, DMS had an in-house collection effort prior to 1989. His memorandum stated that the Division only collected $200.00 and that staff did not feel it was cost effective. Currently, the DMS does not have a method of collecting recipient overpayment resulting from administrative or client errors. Since 1989, Medicaid overpayments for under $1,000 have not been recovered unless they were part of a multiple claim overpayment being collected by the DSI.

The issue of collecting recipient overpayments resurfaced in 1992 and 1993. During this period, DMS staff recommended drafting regulations to cover this area, establishing another in-house program, or contracting with DSI to do collections. A DMS official said that Medicaid Services is now planning to expand its interagency agreement (contract) with DSI to include recovering recipient overpayments.

DSI Collected Some Recipient Overpayments

The Commissioner of DSI said that work is almost completed to transfer Medicaid recipient overpayments that would not be sent to court. Previously, the DSI Collection Branch would collect Medicaid overpayments that were part of general assistance fraud. These are cases in which recipients have been found guilty of fraud involving either Food Stamps or Aid to Families with Dependent Children (AFDC), as well as Medicaid. The revised interagency agreement will

allow DMS to refer other cases. According to the Commissioner of DSI, recipient overpayments identified for FY 1993 total $101,482.69. Records for FY 1991 and 1992 were archived. Collections for FY 1991 were $36,369.14, for FY 1992 $26,685.04, and for FY 1993 $29,695.56 Year ending accounts receivable for FY 1992 was $224,024.17 and for FY 1993, $273,953.95.

Provider Overpayments

Provider overpayments may be recovered through required recoupments or voluntary refunds. According to EDS, during the fiscal years 1992 and 1993, over $27.0 million was set up to be refunded, and a balance of more than $1.8 million remains as of May 21, 1993.

Recoupment, as defined by federal regulations, is a " formal action by the state or its fiscal agent to begin recovery of overpayments without advance official notice by reducing future payments to the provider." Recoupments are performed as a result of overpayments from cost settlements, rate adjustments, billing or processing errors, and fraud and abuse. Federal regulations (42 CFR 433.300) require that the state refund the federal share of any overpayment to a provider. Likewise the state may decrease amounts paid to the Health Care Financing Administration (HCFA) due to underpayments to providers. The state has 60 days from the date that an overpayment is discovered to recover the overpayment from the provider before adjustments are made to the federal share. The adjustments are made at the end of this 60-day period, even if recovery is not made. There are two exceptions: 1) the overpayment is a debt discharged in bankruptcy, 2) the debt cannot be collected (e.g., the provider has gone out of business). In the event of a bankruptcy, the provider must have filed for bankruptcy before the end of the 60-day period and the state must be on

record as a creditor for the amount of the overpayment. If the provider goes out of business, the state must document its efforts to locate the provider and its assets and procure documentation that the provider is out of business and the overpayment cannot be collected. According to the federal regulations, appeals do not affect the 60-day time limit on recovering funds.

EDS Reports Provider Overpayment Balances of More Than $6 Million

Department of Medicaid Services staff stated that several divisions and programs are doing recoupment. So far it has been determined that recoupments are being requested through the Division of Reimbursement Operations, the Surveillance and Utilization Review System (SURS) Branch and KenPAC. Data from Electronic Data Services (EDS) indicates that over $ 1.2 million has been recovered for fiscal years 1992 and 1993. It should be noted that recoupment figures may be overstated. EDS says its recoup/repay adjustment process for correcting claims causes recoupment figures to be inflated. Balances outstanding, as of May 21, 1993, are presented below.

Table 4.1

Cost Settlement and Recoupment Balances
Fiscal Years 1992 and 1993 (a)
(in dollars)

Type of Recovery	Total Balance
Cost Settlement	5,315,040.14
Manual Recoupment	51,717.82
System Generated Recoupment	891,661.41
Total	**6,258,419.37**

(a) Dollar amount as of May 21, 1993.
SOURCE: Electronic Data Systems, Ad Hoc Report # 180, 1993.

Over $1.4 Million Is Outstanding on SURS Accounts Receivable

Kentucky's Surveillance and Utilization Review System (SURS) Branch is responsible for reviewing Medicaid billing and use of services for indications of fraud and abuse. The SURS system identifies providers with billing amounts above the norm for particular services, such as hospital visits, prescriptions, or dental services. Cases of excessive billing are reviewed and investigated if necessary. This includes field investigations and interviewing recipients and providers. Cases are also referred to SURS for review and investigation. At the request of the SURS branch, EDS recoups any overpayments identified. However, these SURS requests for recoupment are not termed fraud and abuse. The documentation sent to EDS reads "SURS review" or "billing errors."

According to EDS, SURS request for 220 providers were identified for Fiscal Years 1992 and 1993. Their combined overpayments totaled more than $2.1 million as of May 21, 1993. (See Table 4.2) SURS overpayments for FY 1992 ranged from $97.50 to $252,782.22, and overpayments for FY 1993 ranged from $20.89 to $275,131.00. The largest overpayments for each fiscal year remain outstanding. Complete information on why these debts remain is not available at this time.

Table 4.2

Summary of SURS Accounts Receivable
(in dollars)

Fiscal Year	No. of Providers.	Total Original Balance	Total Amount Applied	Total Balance
1992	121	922,382.34	613,057.24	309,325.10
1993	99	1,266,873.69	112,013.80	1,154,859.89
Total	220	2,189,256.03	725,071.04	1,464,184.99

SOURCE: Electronic Data Systems, Ad Hoc Report # 153,1993.

Third Party Recoveries

The Medicaid program is designed to be the payer of last resort. Some services paid for by Medicaid may be the responsibility of other parties or insurers. DMS pursues these Third Party Liabilities (TPLs) to recover costs. There are two major types of TPL. One occurs when the Medicaid recipient receives services that are covered by private health insurance or Medicare. The second occurs when a Medicaid recipient is injured in an accident. In these cases some other person or insurance, such as automotive insurance or worker's compensation, is responsible for paying for services.

Two methods are used to pursue TPLs, once they are identified. The first method, known as **cost avoidance**, denies payment from Medicaid, and forces the provider to seek payment from the liable third party. This method is most often used when the recipient has been identified as having had some sort of private health insurance coverage before services were rendered.

The second method, known as **pay and chase**, pays the provider for services and then seeks recovery from a liable third party. This method is used for accident and trauma claims, and when a recipient is later found to have had

insurance coverage when the service was rendered. Towards this end, DMS sends questionnaires to accident and trauma victims who receive services of more than $250 in a five-month period, to identify any liable party or legal action being taken. Attorneys representing these clients are asked to help recover money for Medicaid as part of a settlement. For this service, attorneys may be awarded up to 25% of the amount recovered. Additionally, data matches are performed with several entities, including workman's compensation, child support enforcement, and private insurance companies, to identify TPLs.

Kentucky Does Not Save As Much Cost Avoidance As Other States

DMS estimates that it realized a savings of $25.3 million in FY 1992 and $28.475 million in FY 1993 through the use of the cost avoidance method. Kentucky does not experience as much savings in cost avoidance as some other states. For example, the TPL director in Tennessee, with an annual Medicaid budget of just over $2.7 billion for FY 1993, reported in an interview that her state saved $54 million and $60 million through cost avoidance in the past two fiscal years, while North Carolina (annual budget $2.3 billion) reported saving $31 million and $51 million over the same time. This may be due to the types of claims that are cost avoided or the effectiveness of eligibility staff in identifying potential TPL. DMS could significantly increase cost savings by increasing the numbers of private insurance companies with which data matches are performed. Presently, the Department performs data matches with Medicare, Workers' Compensation, Healthwise and Kentucky Kare. DMS supports legislation requiring private insurance companies to participate in data matches with Medicaid.

Kentucky Collected $11.5 Million of $94.8 Million in TPL Accounts Receivable

DMS reported that third party recoveries from pay and chase activities for FY 1989 through FY 1993 totaled over $16.8 million, with $10.5 million collected from health insurance cases, $6.1 million collected for casualty recoveries, and just over $187,000 in parental medical support. (See Table 4.3) The DMS report gives no indication or estimate of the total amount of third party liability.

Table 4.3

Third Party Recoveries Reported by DMS
FY 1989 -- FY 1993

Fiscal Year	Collections For Health Insurance	Collections For Casualty	Collections For Medical Support	Total
1989	$950,000	$664,414	$3,152	**$1,617,566**
1990	$1,620,428	$579,000	$7,120	**$2,206,548**
1991	$2,066,151	$928,000	$16,254	**$3,010,405**
1992	$2,362,374	$1,308,611	$22,958	**$3,693,943**
1993	$3,521,690	$2,663,431	$137,942	**$6,323,063**
Total	**$10,520,643**	**$6,143,456**	**$187,426**	**$16,851,525**

SOURCE: DMS Division Of Program Development and Budget, September, 1993

Information from the Medicaid fiscal agent, Electronic Data Systems, shown in Table 4.4, puts the total amount of TPL accounts receivable on cases established between January 1987 and August 1993 at over $94.8 million. TPL recoveries, however, for these cases were reported to be just over $11.5 million, a recovery rate of only 12.2%.

Table 4.4

Third Party Recoveries Reported by EDS
All Cases
Calendar Year 1989 -- 1993

Year	Total Cases	Total ICNs (Claims)	Total Medicaid Paid	Total TPL Recovered	Percent Of Recovery
1989	10,191	79,102	$12,897,269	$1,122,017	8.7%
1990	15,009	142,383	$21,484,419	$2,149,363	10.0%
1991	21,880	242,140	$16,479,381	$2,602,266	15.8%
1992	31,630	314,647	$23,932,823	$3,398,558	14.2%
1993	30,259	296,255	$20,039,729	$2,295,771	11.5%
TOTAL	**108,969**	**1,074,527**	**$94,833,621**	**$11,567,975**	**12.2%**

NOTE: Includes transactions to third party accounts receivable files completed as of September 10, 1993.

SOURCE: EDS, TPL Ad Hoc #176, September 10, 1993

According to DMS staff, there are several reasons for the differences in the two figures. The totals from EDS in Table 4.4 show only TPL accounts receivable. Not included in this total are provider claims adjustments ($6.5 million from FY89-FY93), which occur when physicians are compensated by some third party for services already paid for by Medicaid. Providers are required to notify DMS of these payments, with future claims against Medicaid being adjusted accordingly. Also not included in the EDS total in Table 4.4 are payments from parents for medical support, totaling almost $200,000. The remaining differences are explained by the method of accounting for attorney's fees paid out on casualty cases (DMS counts these fees as a part of recovery; EDS does not), the slight difference in the time periods covered, and the method used to classify payments. DMS counts money received towards the fiscal year in which it is received, while EDS credits payments to the cases, which are classified by the year in which they were established.

Kentucky Is Not As Aggressive in Pay and Chase As Other States

Kentucky's activities in some areas of pay and chase are not as aggressive as those of other states. For example, while Kentucky has a $250 threshold for dealing with recovery from accident and trauma claims, other states have adopted a much lower threshold. Virginia's threshold is $50, while North Carolina goes after the first dollar of accident expenses.

The follow-up on billing is another area in which Kentucky could be more aggressive in pursuing TPLs. Presently, for most cases under $1,000, the liable third party is billed a maximum of two times over a six-month period. If no response is received, the case is closed, citing the lack of response. Table 4.5 shows the number of claims from FY 1988 to FY 1993 which were handled in this manner, including moneys expended and recovered by Medicaid. If these accounts had been collected at the average rate for the last five calendar years (12.2%, as shown in Table 4.4), the total amount collected would have been $1,662,842, more than $1.4 million more than was actually collected.

Table 4.5

TPL Receivable Closed Because of No Response in Over 180 Days
FY1988-FY1993

Fiscal Year	Total ICNs* (Claims)	Total Medicaid Paid Amount	Total Recovered
1988	1,305	$122,165	$194
1989	1,089	$335,343	$1,132
1990	14,353	$1,400,875	$38,113
1991	44,395	$2,515,677	$133,030
1992	116,900	$7,049,491	$63,296
1993	54,209	$2,206,304	$1,571

*--Not an unduplicated count. Some of these ICNs could have a different status or be included twice in this count if another liable third party is involved.

SOURCE: EDS, September, 1993

Other states interviewed appeared to be collecting similar, or slightly higher levels of TPL through the pay and chase method than Kentucky. North Carolina officials estimated that they recovered $2 million in each of the last two fiscal years in health insurance recovery and $3.7 million in FY 1992 and $4.3 million in FY 1993 in casualty recoveries. Tennessee reported collecting $2.8 million in health insurance recoveries and $1.7 million in casualty recoveries in FY 1993. Additionally, Tennessee appears to collect a significant amount of identified TPL. For example, of 202 cases closed during the month of August 1993, Medicaid had paid $532,000, and the TPL unit had recovered $209,000, almost 40% of the total identified TPL.

Fiscal Agent Has More TPL Responsibility in Kentucky Than TPLs in Other States

One of the major differences between Kentucky and the two other states interviewed was the role of the fiscal agent in pursuing TPL. In both Tennessee and North Carolina, the fiscal agent is responsible for identifying TPLs, sending bills to insurance companies and sending questionnaires to clients in accident and trauma cases. Replies and payments then come back to the state Department for Medicaid Services, which also pursues payment. North Carolina has a staff of 22 in its TPL section, while Tennessee has a staff of nine.

In its capacity as fiscal agent for Kentucky, EDS is responsible for identifying TPLs, pursuing payment of liable third parties, and receiving payments from third parties. EDS estimated its cost for performing TPL services at 1.8108 cents per claim processed, approximately 4.25% of the total cost of 42.61 cents per claim processed. During the last fiscal year, EDS received $13.8 million from its contract with DMS, of which $586,500 went to TPL activity, according to the EDS cost estimate. The amount of recovery ($11.5 million of a total $94.8 million) raises the question of the effectiveness of EDS in pursuing these recoveries.

RECOMMENDATION #10: DMS Should Be More Aggressive in Pursuing Overpayments and TPLs

DMS should increase its efforts in the areas of recipient and provider overpayment recoupments. DMS should work more aggressively towards identifying potential TPLs and pursuing payment of TPLs, to increase cost savings in the Medicaid program. Strategies for TPLs that could be utilized to implement this recommendation include:

- **Performing data matches with more private insurance companies, to identify potential TPLs.**
- **Lowering the threshold on accident and trauma claims.**
- **Pursuing collection of identified TPLs more aggressively, by not closing cases for lack of response.**
- **Investigating the feasibility of establishing a TPL collection unit under DMS.**
- **Investigating the feasibility of employing private collection agencies in TPL collection.**
- **Considering the feasibility of billing Medicaid recipients if a potential TPL exists.**

CHR FOLLOW-UP RESPONSE, JANUARY 1996

1. Accounts Receivable Report with aged status has been provided.

2. Accounts Receivable for TPL report will be forwarded to you as soon as it is available from the UNISYS system.

3. Accounts Receivable for Drug Rebate will be forwarded to you as soon as it is available from the UNISYS system.

4. Accounts Receivable for recipients 907 KAR 1:675E (see pages 10 and 11 of the regulation) became effective February 1, 1995. The DMS is in the process of modifying its contract with the Department for Social Insurance to

designate that agency as responsible for implementation of these new regulatory requirements.

5. The Office of Inspector General (OIG) has the responsibility to develop this information concerning the status of Accounts Receivable for the progressive Health Report and follow-up. We have notified OIG of your request and will forward the information at a later date, when it is received from that office.

6. An update on the status of the accounts receivable for EPI, William Sizemore and Primary Care Center of Adair County has been provided.

7. An update on the status of the Adanta accounts receivable has been provided. The federal share has been returned to HCFA on this receivable.

8. Appeals process. Please refer to Section 14 of the enclosed regulation 907 KAR 1:671, which is now in effect and deals with administrative hearings, which has been provided.

9. Appeals over 60 days without resolution have been provided.

10. SURS accounts receivable. The provider receiving a request for refund of a SURS post-payment review can appeal the findings as follows: Within 30 days from the date of the findings letter, the provider may submit written additional information, request a resolution meeting, and/or request an administrative hearing.

Additional Information: If the provider submits additional information, it is reviewed by the Department and SURS, with a decision transmitted to the provider from the Department within 30 days from receipt. Should the provider

disagree with the decision at this level, a resolution meeting is held, if requested within 30 days of the findings letter. However, if the provider did not request a resolution meeting or hearing originally, he is given 30 additional days from decision letter date to request an administrative hearing.

Resolution Meeting: A resolution meeting is conducted in an informal manner with the provider afforded the opportunity to present any evidence or testimony to the Department and to the SURS reviewer. Upon review of additional documentation submitted at the resolution meeting, a decision is transmitted to the provider within 30 days from the date of the meeting. Should the provider disagree with the decision at this level, he is, again, given 30 days from the decision date to request an administrative hearing.

Administrative Hearing: An administrative hearing is conducted by an impartial hearing officer appointed by the Secretary of the Cabinet. The hearing officer's decision is submitted to the Secretary in the hearing report, issued within 60 days of the closing of the record. The provider is given ten days to file exceptions to the hearing officer's decision with the Secretary, who makes the final agency decision.

The Department for Medicaid Services continues to work with the Division of Audits and the Surveillance and Utilization Review Subsection in an attempt to reconcile older accounts receivable. All Medicaid providers which have current outstanding accounts, not pending litigation, will be assured administrative due process and collection of amounts due on a timely basis.

Staff Follow-up Response, January 1996

1. Accounts receivable for period ending November 30, 1995.

Under 45 days	Under 90 days	Over 90 days	Over 120 days
$4,573,546	$2,225,875	$1,877,244	$12,952,266

Federal law (CFR 433.316) states that the date on which an overpayment is discovered is the beginning date of the 60-calendar-day period allowed a state to recover or seek to recover an overpayment before a refund of the federal share of an overpayment must be made to HCFA. Based on this law, the DMS should have returned to HCFA approximately $10.4 million without having recovered anything from providers who have been overpaid.

The DMS could have used this period of interim payments as a resource to collect funds owed the State from providers. According to a DMS official, this was not done.

The Adair County Primary Care Center had a second level of appeal; however, the decisions from the panel were not transmitted to the provider. Therefore, an administrative hearing was scheduled.

7. Total payback as of May 19, 1995, was $3.8 million. To date, no funds have been received by the DMS from Adanta. The DMS has repaid the federal share of approximately $2.6 million to HCFA.

8. Information provided.

9. Appeals listed indicate no final resolution. The list is inclusive of appeals for fiscal years 1991-1994.

10. No accounts receivable for SURS was included.

CHAPTER V

DRUG UTILIZATION

In the Medicaid study request presented to the Program Review and Investigations Committee in May 1993, the pharmacy program was cited as an illustration for potential overutilization. Recent newspaper articles have connected nerve pill abuse with Medicaid patients, particularly in eastern Kentucky. Information from ad hoc reports on drug utilization in the Medicaid program is presented here. However, no conclusions are offered at this time. Aspects of the Medicaid program that may be used to detect and/or prevent drug overutilization, abuse and fraud are discussed.

Program Review staff requested reports on drug utilization to determine whether there is an appearance of inappropriate drug utilization. Staff reviewed reports containing the top 100 codeine Medicaid prescribers and suppliers, a report detailing information on the top 200 Medicaid narcotic suppliers, the top 200 Medicaid recipients utilizing narcotics, and the top 200 drugs dispensed for Medicaid recipients.

Scheduled Drugs

An ad hoc report identifying the top 200 dispensed drugs to Medicaid recipients shows that one strength of an Acetaminophen with Codeine

(APAP/COD), a codeine compound, accounted for the second highest number of prescriptions written. This APAP/COD dosage is second only to Cefaclor, a type of Cephalosporin Antibiotic. The drugs are identified by their National Drug Code (NDC) number. NDC numbers are different for each dosage of the drug. Therefore, varying dosages of APAP/COD or other drugs will appear several times in the top 50 dispensed Medicaid drugs. The first codeine compound in a list identifying the top 200 drugs prescribed in the United States is number 26. Table 5.1 identifies the top 50 prescribed types of drugs.

Codeine Compounds Are the Most Prescribed Scheduled Drugs

A report identifying the top 200 narcotic claims submitted by the pharmacies overwhelmingly listed APAP/COD as the most widely utilized narcotic. Table 5.2 identifies the prescribed narcotics, the number of prescriptions, the number of recipients served and the total Medicaid population for each identified county by paid claims.

The Majority of Top 100 Codeine Prescribers Are Located in Eastern Kentucky

Map 1, below, shows each county and the number of physicians in each that have been identified as one of the top 100 Codeine prescribers in the Medicaid program.

TABLE 5.1

G:Medicaid\AKH10.XLS

TABLE 5.2

G:Medicaid\AHJB8.XLS

Table 5.2 Continued

Insert Map 2

Physician

Insert Map

Pharmacy

Map 2 shows that the top 100 Codeine suppliers are located geographically much like the top 100 codeine prescribers. There are a few differences. There are pharmacies in Powell, Estill, Oswley, Leslie and Magoffin counties where there are no top 100 codeine prescribers located.

Six Top 100 Codeine Physician Practices and Pharmacies Have the Same Address

Five physician practices, each with two physicians, and another practice, with one physician, identified as being among the top 100 codeine prescribers have the same address as a pharmacy identified as a top 100 codeine provider. As the Department of Medicaid Services has not requested or monitored disclosures of Medicaid providers, Program Review staff was unable to determine whether these physicians have ownership in the pharmacies. Five of these practices are in eastern Kentucky counties, Bell, London, Knox, Whitley, Floyd and Breathitt. The other practice is located in Jefferson County.

The Majority of the Top 200 Medicaid Recipients Utilizing Narcotics Are Institutionalized

A staff review of an ad hoc report identifying the top 200 Medicaid recipients utilizing narcotics during the past two years revealed that the majority of the recipients are in institutions. Recipients in institutions such as Hazelwood, Oakwood and the Home of the Innocents accounted for at least 25 of the utilizers. Additional recipient addresses were identified only as

Guardianship Services in Frankfort; however, it is likely that at least some of these recipients are also located in institutions.

Surveillance and Utilization Review

The Surveillance and Utilization Review Branch (SURS) reviews providers and recipients who "except" the norm or have a higher than average utilization rate than their peers. The exception logs identify those who appear to have high utilization of a service or services. Federal policy requires that SURS review .05%, or in Kentucky, approximately 60 active providers, and .01%, or in Kentucky, approximately 50 active recipients, per quarter. A minimum of 80% reviewed must be selected from the exception logs. Kentucky SURS staff indicated that they try to review almost all of their cases from the exception log, however; and they will review a referral or a problem that may be identified during another review.

The Department of Medicaid Services Has Never Placed a Provider on Lock-out

While the review may be initiated by the exceptions, according to SURS staff, when the full review is conducted, all services provided or received are reviewed. For example, if a physician is reviewed initially as a result of an exception due to high number of office visits, in the course of a full review, if he also appears to be writing a high number of codeine prescriptions, this should be detected by the SURS staff.

There appear to be some questions regarding what actions the SURS Branch can take if they do detect abusive or questionable prescribing practices.

The Cabinet policy dictates that the Cabinet may suspend or terminate a provider for good cause. The good cause definition includes: misrepresenting or concealing facts in order to receive or to enable others to receive benefits, and furnishing or ordering services under Medicaid that are substantially in excess of the recipients' needs or that fail to meet professionally recognized health care standards. A suspension may also be based on a felony conviction involving Medicaid. Even though the CFR has provisions for a provider lock-out, Kentucky Medicaid Services has never ordered a provider lock-out.

Program Review staff discussed several SURS Activity Reports with SURS staff and the Program Services Director. Two cases involved quality and competency of care issues. The SURS staff discussed with one physician the high volume of codeine compounds prescribed by the physicians in his office. He admitted there was a high volume but said he couldn't stand for his patients to be in pain. He knew some of them were addicted. The other case involved a physician who had ongoing personal drug and alcohol problems. Professionally, he had been barred from practicing in his local hospital and could not write prescriptions for controlled substances for himself or others. He moved to another location and continued to practice. SURS staff had conversations with the Drug Control Branch and the Medical Licensure Board regarding this physician. However, the physician remained a Medicaid provider and was an eligible KenPAC provider.

The Program Services Director, while acknowledging that some follow-up should have been done in the first case, also informed Program Review staff that as long as a physician has a medical license, the physician can be a Medicaid provider. Subsequent conversations with SURS staff indicated that the staff feel that they have no authority or jurisdiction to handle these issues.

Program Review staff reviewed approximately five hundred SURS provider activity reports to determine how the reports are used in oversight and monitoring. A case can be completed with various findings. Common findings include: no problems were detected, billing errors were found and there may or may not be a refund request, or referrals were made to other agencies of jurisdiction. However, no monitoring or reporting is done to determine the final resolution or disposition of a report. Once the report is completed, the case is closed by SURS staff. SURS staff indicate that a lack of directives, guidelines or criteria to define "substantially in excess of recipients' needs" or "professionally recognizes health care standards" limits their authority.

RECOMMENDATION #11: Development of Utilization Guidelines and Criteria

The Department for Medicaid Services should develop guidelines and criteria to define appropriate utilization to meet recipient needs and recognized standards of health care.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

No response necessary.

Staff Follow-up Response, January 1996

907 KAR 1:677E was filed December 5, 1995, to promulgate regulations to identify misutilization of Medicaid Services.

Recipients over-utilizing services can be placed on lock-in. The lock-in program requires the recipient to choose one physician and one pharmacy for

services. However, there are loopholes that can inhibit the effectiveness of this alternative to managed health care. If the recipients or providers do not comply with the program, there are no penalties.

Recipients Over-utilizing Services Can Be Placed on Lock-in

A recipient review is conducted much like a provider review. The only difference is the outcome or resolution of the review. A recipient is not asked to reimburse the program for any unnecessary or excessive services. The Lock-in program requires the recipient to choose one physician and one pharmacy for services. The recipient should not seek services from any other provider unless their Lock-in provider makes a referral.

Lock-in could serve as one means of managing the health care of a recipient who has been determined to be abusive. The recipient can be on Lock-in for a minimum of two years. The recipient may be released after this period, if there is a physician's request and/or the recipient has demonstrated proper utilization of program services. However, there are loopholes that can inhibit the effectiveness of this alternative to managed health care. Staff reviews of recipient SURS activity reports found recipients who had previously been on Lock-in and released and had been later reviewed for excessive service utilization. These recipients were placed on Lock-in again. However, if the recipients or providers do not comply with the program, there are no penalties.

One recipient SURS activity report identified a recipient who visited one practice regularly. Upon examining the records, it was found that the recipient visited the office at the beginning of the month, saw Dr. #1, received a 30-day supply of his medication, visited again at the middle of the month, saw Dr. #2,

received another 30-day supply of the same medication, and then came again at the end of the month, saw Dr. # 3, and received yet another 30-day supply of his medication. The SURS staff recommended lock-in; however, the report noted that if this recipient selects this practice as their provider, lock-in will do little in preventing abuse.

Program Review staff performed a review of 97 recipient SURS activity reports. Sixty-seven reports identified excessive or abusive use of codeine. An additional thirteen reports identified drug overutilization, but did not mention codeine specifically; however, codeine had been prescribed. An additional eight reports identified overutilization for drugs other than codeine compounds. Only nine reports reported no problems with drug utilization. Confidential information regarding the recipient's identification number or address was not provided with these reports. Staff was not able to determine where these recipients were located. However, of the sixty-seven reports with SURS staff identification of excessive use of codeine, sixty-one recipients utilized at least one physician or pharmacy in the top 100 codeine provider list. Most recipients utilized multiple physicians or pharmacies in this group.

RECOMMENDATION #12: Freedom of Choice Waiver for Lock-in Recipients

The Department for Medicaid Services should study the effectiveness of amending the State Plan to request a wavier to restrict freedom of choice provisions. The restrictions would allow the Department to assign a recipient placed on lock-in to a Medicaid provider in lieu of allowing the recipient to choose their lock-in provider.

CHR FOLLOW-UP RESPONSE, JANUARY 1996

No response necessary.

Staff Follow-up Response, January 1996

907 KAR 1:677, filed December 5, 1995, addressed the Medicaid recipient lock-in.

Kentucky established a Drug Use Review and Advisory Board (DURAB) effective January 1993. Established to comply with federal requirements, the program assures that prescriptions for outpatient drugs are appropriate, medically necessary, and are not likely to have adverse medical results. The DURAB has appointed a subcommittee to review quality drug therapy.

The Kentucky Drug Use Review Service have been in operation since February 1988. Five regional drug utilization review boards review recipient usage. The boards are composed of two private practice pharmacists and one private practice physician. A review is conducted in such a manner as to determine recipient usage, and not physician or pharmacy dispensing patterns.

The Medicaid Abusable Drugs Audit System (MADAS) will analyze and identify patterns of high drug utilization. The DMS received the MADAS from the U.S. Office of Inspector General this past year. At this time, the Department is developing its plans on MADAS utilization and program implementation.

KenPAC drug utilization control relies on the participants, recipients and providers. The DMS established the criteria for drug pre-authorization. The Department has stated that the prior authorization program assists in controlling

cost and drug abuse. However, it appears that the program has not been evaluated to determine the effectiveness in lowering costs or abuse.

For FY 93, EDS received 153,311 requests for drug pre-authorization. Ninety-three percent were approved.

Drug Utilization and Review Board Established

Kentucky's Drug Use Review and Advisory Board (DURAB), discussed above, is designed to provide educational information to physicians and pharmacists to assist in identifying and reducing fraud, abuse and inappropriate use of specific drugs. The DURAB members, composed of private physicians, pharmacists, and an advanced registered nurse, were appointed in January 1993. The board has conducted four meetings. At its fourth meeting, held August 12, 1993, board members expressed concern regarding the restraints placed on the members. Board members have been instructed that there is a prohibition against ex parte communication by interested parties who have items on the agenda and that due process must be observed. However, this interpretation appears to include prohibition against ex parte communication among board members and staff. At the same time, board members have also been instructed numerous times that they are only an advisory board, and that the final action on any recommendations rests with the Commissioner of the Medicaid Services Department.

The DURAB has appointed a subcommittee to review quality drug therapy. The issue of overutilization of narcotics has been discussed as a primary issue for its review. The first meeting was scheduled for mid-September.

Five Regional DUR Boards Review Recipient Usage

The Kentucky Drug Utilization Reviews (KDURs) have been in operation since February 1988. The boards are composed of two private practice pharmacists and one private practice physician. They review cases that have been selected by the program administrator, First Health. First Health reviews paid claims provided by EDS and selects cases for board review. If the board determines that there could be a problem due to drug interaction, or diagnosis, a letter is sent to the attending physician, providing him with the information.

A review is conducted in such a manner as to determine recipient usage, not physician or pharmacy dispensing patterns. Once a letter is sent to the physician, the case is closed. Occasionally a recipient may be referred to SURS for lock-in consideration.

MADAS Will Analyze and Identify Patterns of High Drug Utilization

The Department for Medicaid Services received the Medicaid Abusable Drugs Audit System (MADAS) from the US Office of Inspector General this past year. The Department sent a provider letter, dated August 20, 1993, to Medicaid providers, informing them of this system and the Department's intent to utilize the system as a way to detect excessive usage of controlled substances. This information will include activities by prescribers, dispensers and recipients. A committee has been formed within the Department to review the data compiled by MADAS. At this time the Department is developing its plans on MADAS utilization and program implementation.

KenPAC Drug Utilization Control Relies on the Participants, Recipients and Providers

KenPAC (Kentucky Patient Access Care) serves the Medicaid program as a case management health care system. The program was developed by the Department for Medicaid Services and has been in operation since February 1986. KenPAC was created to provide and assist the AFDC and AFDC-related eligible to obtain appropriate and proper health care. There is no penalty for failure to comply with the program guidelines. Physicians receive $3 per month per KenPAC participant enrolled with the physicians, regardless of how effectively that provider manages the health care of the recipient.

SURS recipient activity reports revealed recipients who were abusing and excessively utilizing services while enrolled in the KenPAC program. In addition, Program Review staff requested an ad hoc report listing the top 200 Medicaid recipients utilizing scheduled drugs. While at least 50% of the recipients identified in this report are institutionalized, there were six recipients identified as KenPAC participants for all or a portion of their pharmacy utilization during the period between June 30, 1991, through July 1, 1993. Two recipients are identified as receiving over 1,000 days' supply each of APAP/COD, a codeine compound, during this timeframe. Two additional KenPAC recipients appear to have received excess days' supply of Methylphenidate (Ritalin) for the time period.

Prior Authorization Required for Some Drugs

The Department of Medicaid established the criteria for drug pre-authorization. The Department has stated that the prior authorization program

assists in controlling cost and drug abuse. However, it appears that the program has not been evaluated to determine the effectiveness in lowering costs or abuse.

EDS, as part of its contract, provides prior authorization for pharmacy services. In another state survey conducted by DMS staff regarding drug pre-authorization, only three of the 16 states responding with drug pre-authorization programs use a contractor or fiscal agent to handle drug pre-authorization. The cost for this portion of Kentucky's contract with EDS is estimated at $1.3 million. Neither DMS nor EDS staff could provide an exact cost for the program, but EDS agreed not to disagree with this estimate provided by DMS.

EDS staff address prior authorization requests Monday through Friday, 8:00 a.m. to 4:30 p.m., excluding holidays. If a physician calls beyond the office hours, it is at his discretion whether to dispense the drug or to wait for approval during the next working day. Program Review staff asked EDS if the set office hours pose problems for providers, especially those in a different time zone. EDS responded that the office hours did not interfere with access to prior authorization and that providers did not call for authorization beyond their office hours. If that situation arose, EDS worked with DMS to agree on approval. DMS staff stated that the office hours were no problem; EDS staff just backdated the prior authorization request to the prescription date, if the request matched approval criteria.

For FY '93 EDS received 153,311 requests for drug pre-authorization. Ninety-three percent were approved.

CHAPTER VI

REQUESTED REVIEWS OF THE KENTUCKY MEDICAL ASSISTANCE PROGRAM

At the request of the Program Review and Investigations Committee, pursuant to KRS 6.935, the Auditor of Public Accounts conducted and contracted reviews of certain elements of the Medicaid program. The Auditor of Public Accounts staff conducted reviews of the non-emergency medical transportation and provider enrollment process. The Auditor's office contracted with Coopers and Lybrand for reviews and audits of the Medicaid Management Information System, the Medicaid Assessment Revolving Trust Fund, and the Medical Assessment Improvement Trust Fund.

Auditor of Public Accounts - Medical Non-Emergency, Non-Ambulance Transportation System

During fiscal year 1993, non-emergency, non-ambulance transportation costs exceeded $13.5 million. Normally these services are pre-authorized by the Department of Social Insurance staff through their contractual agreement with the Department of Medicaid Services. The objective of the survey was to identify potential areas for detailed review.

Approximately 97% of providers were individuals driving private automobiles. During fiscal year 1993, there were over 4,500 paid transportation providers, with approximately 97% of those being individuals driving private automobiles. Of the $13.5 million total non-emergency cost, approximately $400,000 was paid to individuals with commercial carriers receiving the balance. Of the 147 commercial carrier providers, 20 received over $8 million of the $13.5 million.

Sample Commercial Carrier Providers Should Be Reviewed

The Auditor of Public Accounts recommended that a sample of commercial carrier providers be selected for a detailed review. The review included the following:

- Visiting local offices to determine whether the staff are following proper procedures. A determination that the least expensive suitable type of transportation was used.
- Visiting providers to review supporting documentation and ascertain comments.
- Visiting physician's office to verify the recipient had an office visit the day of the transportation claim.

The review determined whether internal controls were working properly.

Auditor of Public Accounts - Medicaid Provider Integrity

The Auditor of Public Accounts staff reviewed the Department of Medicaid Services controls over the integrity of providers and the program. Recommendations were made to enhance program integrity and staff indicated that federal regulations provide for more stringent enforcement of the program.

Considering Performing Periodic Background Checks

Providers who are subject to licensing regulations are required to submit evidence of a current license. The licensing process requires information related to criminal activity. Home Health Care agencies receive licenses from the Division of Licensing and Regulation. Agency employees must meet certain qualifications, but criminal background checks are not conducted. Taxi drivers are not regulated; therefore, no such check is made on them.

Reviewing Organizational Placement of the Surveillance and Utilization Control Program

The Auditor of Public Accounts staff indicated that a key area of program integrity is the existence of the Surveillance and Utilization Control Program. The program safeguards against unnecessary or inappropriate use of Medicaid services and excess payments.

The APA recommended the Cabinet review the organizational placement of the Surveillance and Utilization Control Program. The APA staff concluded that the strength of the program could be enhanced if the review group reported to Cabinet officials independent of the Department of Medicaid Services.

Audit of Coopers and Lybrand, Medicaid Provider Assessments and Benefits Under the Medicaid Provider Tax Assessment Program

At the request of the Program Review and Investigations Committee, and in compliance with KRS 205.577 (14), the Auditor of Public Accounts contracted an audit of the Medicaid Assistance Revolving Trust (MART). The audit was

performed by the audit firm Coopers and Lybrand, certified public accountants, for the period from inception (July 13, 1990) to June 30, 1991, and for years ending June 30, 1992, and 1993.

The Hospital Indigent Care Assurance Program (HICAP) was established in 1990 as a proactive tax assessment and payment program. The MART fund received funds collected from hospitals and other providers during the period under the audit amounting to $394,526,811, with benefits distributed to providers of $792,496,614 (including federal match).

Compliance with Applicable Laws and Regulations.

According to the report on the Audit of Schedule of Medicaid Provider Assessments and Benefits Under the Medicaid Provider Tax Assessment Program, "Compliance with laws, regulations, contracts, and grants applicable to the Program is the responsibility of CHR's management. As part of obtaining reasonable assurance about whether the schedule is free of material misstatement, we performed tests of CHR's compliance with certain provisions of laws, regulations and contracts. However, the objective of our audit of the schedule was not to provide an opinion on overall compliance with such provisions. Accordingly, we do not express such an opinion. Also, our compliance tests were not designed to satisfy the requirements of The Single Audit Act of 1984 or Office of Management and Budget Circular A-128. Those requirements will be satisfied by audits performed by the Office of the Auditor of Public Accounts of the Commonwealth of Kentucky, and his reports thereon will be issued separately from this report.

The results of our tests indicate that, with respect to the items tested, CHR complied, in all material respects, with the provisions referred to in the preceding paragraph. With respect to items not tested, nothing came to our attention that caused us to believe that CHR had not complied, in all material respects, with those provisions".

Medicaid Management Information System - Coopers & Lybrand

The Auditor of Public Accounts contracted with Coopers and Lybrand to perform a review of the contractual agreement between the DMS and EDS. The review also surveyed fiscal agent contracts for Alabama, North Carolina, Tennessee and West Virginia as a means of comparison.

Payment claims are processed and prepared for payment through the Kentucky Medicaid Management Information System (MMIS). Since fiscal year 1989, costs have doubled for this service. The cost in 1989 was $6.6 million; current costs exceed $13.8 million.

The Medicaid Management Information System (MMIS) began operation in 1981, with Kentucky operating its own system. In 1983, Electronic Data Systems was awarded the first fiscal agent contract, at a price of $0.3997 per claims for a three-year period. The DMS exercised two one-year extensions of the contract at $0.5075 per claim. In 1988, EDS was again awarded the contract, at a price of $0.4048 per claim for a three-year period. Again, in 1991, a two-year extension of the contract was exercised, which included an increase based on the CPI. The DMS released a Request For Proposal (RFP) to procure service of a fiscal agent in 1992. Later that year the RFP was suspended and DMS negotiated an additional one-year extension to the contract with EDS, at

$0.4261 per claim, up to a threshold of 32 million claims. The rate dropped to $0.3761 for the next 2 million claims, and then to $0.3561 for additional claims. In 1993, the DMS hired an outside consultant to assist with preparation of a new RFP. The consultant determined the need for an additional extension of the EDS contract to allow time for procurement and implementation of a new contract.

The Executive Summary of the review for the Kentucky MMIS, inclusive of the approach, findings and recommendations, is provided in Appendix C. The review in its entirety is located in the Auditor of Public Accounts office for public inspection.

Coopers and Lybrand Selected Functions for Manual and/or PC-Based Systems

In response to Recommendation 2 of the Program Review and Investigations study of the Kentucky Medical Assistance Program, the Cabinet for Human Resources contracted with Coopers and Lybrand to review the manual and/or PC-based systems within the DMS. The objective of the review was to identify processes that are tracked by the computer system, establish the purpose for the system, and identify opportunities to streamline the process.

Based upon the findings in claims management review and operations audit, the contractor identified several areas for additional analysis and quantification of potential savings. Appendix D includes savings estimates based on fiscal year 1993. In addition, the report identifies other opportunities for significant savings in the Kentucky Medical Assistance Program.

APPENDIX A

MEMORANDUM

TO: Program Review & Investigations Committee

FROM: Doug Huddleston
Project Coordinator

SUBJECT: Medicaid Review

DATE: December 12, 1994

Program Review staff was asked to do an update on the Kentucky Medical Assistance Program Study that was presented on September 13, 1993. The following information is a result of that effort.

MEDICAID FRAUD HOTLINE PROCESS/IMPLEMENTATION

THE ISSUE: The previous and/or current methods used by DMS to address complaints of fraud and abuse by the public have come under question.

The Code of Federal Regulations (CFR) 42-455.21 states:

"In a state with a Medicaid fraud control unit established and certified under subpart C of this part,

(a) The agency must-
(1) Refer all cases of suspected fraud to the unit;"

BACKGROUND: Questions arose as to the effectiveness of the Medicaid Hotline. There was concern that complaints coming in to the Hotline were not being followed through, and the telephone was not advertised or displayed in locations that would be conducive to an effective system. A staff member who has been answering the Hotline for the past three years had never received training. Approximately three weeks ago the staff member was given a question sheet for referrals to incoming calls.

WHAT THEY ARE DOING: As of December 1994, the Medicaid Hotline is shared with the welfare fraud hotline, with 1 common 800 number. An official in the Office of Inspector General informed staff that a dedicated phone line for Medicaid is to be installed in the near future. Currently staff members from the OIG meet each Monday morning to discuss Hotline activity of the previous week and to coordinate the proper actions to be taken. The meeting on December 5, 1994 established a formal method of addressing Hotline complaints. This meeting was the first ever where members of the AG's office were present. Training methods were established along with procedures for logging all calls. Of the 34 complaints discussed at the Monday morning meeting, seven were issued to the MFCU of the Attorney General's office, with the balance being handled within the Cabinet.

Another member of the OIG staff indicated that 6 lines plus the common welfare fraud 800 number, are now being used, as of the first of December. After-hour calls are taken by a machine and followed up the next working day. This procedure began the first week of December. Also, a rollover process was added in December to the phone system, with all Special Investigations staff being involved with answering the phones. No outcomes of previous calls were available to PRIC staff. Formal training will begin in the near future for staff involved in answering the phones.

Public information regarding the hotline is now being updated, with new posters and mailings to be instituted in the near future. Staff of the Attorney General's office indicated that when Medicaid cards are mailed to recipients, an information sheet could be included to inform recipients how to report fraudulent or abusive practices.

LOCK-IN AND LOCK-OUT USAGE

THE ISSUE: Recommendation #12 proposed the DMS request from HCFA a freedom of choice waiver for Lock-in recipients. The Lock-in and Lock-out Programs were instituted to address recipient over-utilization of services and fraudulent and abusive provider activities. The DMS appeared to be ineffective in implementing these programs.

BACKGROUND: In the Kentucky Medical Assistance Study it was recommended that DMS determine the effectiveness of requesting a waiver

from HCFA to amend the state plan to restrict freedom of choice for Lock-in recipients, to enhance the state's ability to address over-utilization, fraud, and abuse by recipients. The restrictions would allow the DMS to assign a recipient to a Medicaid provider, rather than allow the recipient to continue to "doctor shop" to choose a provider who facilitates their abusive practices.

Provider Lock-out has experienced problems, due to a conflict in provider manuals, according to an OIG staff member. Additionally, it is unclear whether the DMS has ever revoked a provider agreement.

WHAT THEY ARE DOING: The Lock-in Program is currently experiencing problems. Abusive recipients continue to "doctor shop" until they find one that suits their needs. The DMS has not applied for a freedom of choice waiver or taken any other actions that would address this problem. The DMS stated in its June 1994 update that a waiver from HCFA regarding freedom of choice is not required, although in the initial Medicaid study this was cited as the reason the Lock-in program was not successful. Additionally, OIG staff indicated physicians' reluctance to accept Lock-in recipients, for obvious reasons.

The Office of Inspector General staff indicated that with the implementation of Regulations addressing HB 127, these areas should be readily corrected. The regulations are currently in process.

SURVEILLANCE AND UTILIZATION REVIEW

ISSUE: The SURS Unit mandated by the Code of Federal Regulations was found to be, in part, ineffective during the initial Medicaid Study. While the SURS unit was answering the federal mandate of monitoring a select number of cases, follow-up, recoupment, and action plans developed around trends were virtually non-existent.

The Code of Federal Regulations CFR 42-456.3, Statewide surveillance and utilization control program, states that :

"The Medicaid agency must implement a statewide surveillance and utilization control program that-

(a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;

(b) Assesses the quality of those services;

(c) Provides for control of the utilization of all services provided under the plan in accordance with subpart B of this part; and

(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part."

CFR 42-456.4, Responsibility for monitoring the utilization control program, states in part that:

(a) The agency must-

(1) Monitor the statewide utilization control program;

(2) Take all necessary corrective action to ensure the effectiveness of the program;"

BACKGROUND: During the initial part of the Medicaid Study, PRIC staff found that the SURS unit appeared to be fulfilling the requirements of the CFR, although the DMS was ineffective in taking corrective actions, such as recovering funds and sanctioning providers and recipients. PRIC staff found that $1.46 million was in the accounts receivable, with questionable efforts by DMS to recover these funds.

Once the SURS unit discovered potential problem providers, and an investigation was conducted, the recommendations of SURS were not followed through. The division for following through on recoveries was not making efforts to notify providers of the questionable activity. Upper management was not using the information as a management tool, to plan for efficiency.

WHAT THEY ARE DOING: The SURS unit was moved to the Office of Inspector General. Since the move has occurred, the unit has taken action on all of the accounts receivable. A Hearing Officer (single level appeal) has been used to expedite the appeals process. In the case of one provider, $90,000 has been collected, with the provider receiving a thirty-day suspension. The other cases are pending appeal, with hearings currently in process.

The SURS unit, through the Division of Audits, has sent to the DMS $600,000 of additional accounts receivable since the unit was moved to the OIG. Computers have been purchased for the unit, which will enhance their ability to readily identify and resolve potential problem cases. An additional $132,000 in field equipment has been approved to improve and expedite field investigations and audits. Problems appear to persist in the recovery of SURS identified accounts receivable. A letter is generated through the Division of Audits notifying DMS to recover funds. The DMS Division Director indicated there was insufficient data provided to begin collection procedures, although the letter is signed by an authorized official within the OIG. Of the $600,000 sent to the DMS, no funds had been recovered.

MEDICAID FUND RECOVERIES

THE ISSUE: Recommendation #10 indicated that the DMS should increase its efforts in the areas of recipient and provider overpayment recoupments. The department should work more aggressively towards

identifying potential third party liabilities and pursue payment of TPLs to increase cost savings in the Medicaid Program.

BACKGROUND: During the initial Medicaid Study, the DMS could not provide accurate information pertaining to recoupment/recoveries of Medicaid funds. By requesting Ad-Hoc reports from Electronic Data Systems, the fiscal agent for the DMS, PRIC staff identified recoupment and cost settlement balances of $6.2 million. Additionally, accounts receivable for third parties exceeded $83 million, and over $1.4 million was identified in SURS accounts receivable. Recipient recoupment had been non-existent, since a reorganization plan of 1989 had "inadvertently forgot" to include recipient recoveries/recoupment.

The appeals process appeared to be a major obstacle in the recovery of funds. The process appeared to be untimely. Additionally, the Division Director of the Reimbursement Section sat on the first and second level of appeals, which appeared to be inappropriate.

The follow-up audit, conducted by the Office of Inspector General of the Progressive Health Audit, indicated a lack of coordination between the DMS staff and the fiscal agent. The OIG went on to recommend that Medicaid screen all billings for Medicare eligibility. When Medicare eligibility is indicated, but no Medicare payment is reflected on the billing, payment should be suspended and the billing re-routed, pending disposition by a unit handling information from Medicare carriers. As a result of the OIG audit, $1.2 million of the potential recoveries of $1.5 million was identified as "amounts questioned and which are the result of costs which should have been paid by third party payers; principally Medicare". The OIG staff went on to conclude that, "this figure ($1.5 million) is probably understated due to other subrogation factors, physician charges, and further verification relating to additional charges".

WHAT THEY ARE DOING: The DMS currently lacks the ability to readily identify funds in the recovery process, even though Administrative Order 94-02 established an Accounts Receivable Section effective January 28, 1994. Although the Program Review and Investigations Committee informed the DMS on November 10, 1994 that the types of information that would be requested involved recoupments, pending, recovered, and in-process, this information was not available until December 9, 1994.

Currently the appeals process appears to be a major obstacle in resolving these issues. The current appeals process still involves the Division Director sitting on the first and second levels of appeal. Department staff indicated this would be changing soon, with the signing of new regulations which address these problems.

As stated previously, of the $600,000 sent to the Reimbursement Division from the SURS unit to be recovered from providers, no funds have been collected, nor has the initial process begun.

The DMS reports that of the $16.6 million paid in 1994, which should have been paid by third parties, only $31 thousand has been recovered.

On November 18, 1993, memorandums from the General Counsel and Commissioner of Medicaid were issued to demand repayment of the above mentioned $1.5 million in questioned payments, which involved the $1.2 million of third party payments. As of December 9, 1994, only $56,000 of the questioned payments had been collected . It would appear that these recoveries would be made in a timely fashion, since the Medicare carrier under Part B had ruled many of these medically unnecessary. The follow-up audit stated that many of these services were paid by the DMS for many months following the Medicare denials.

In the September 13, 1993 Program Review Committee meeting , two providers were mentioned as having owed the state large amounts of money for extended periods. One had owed the state over $2 million, with the questionable activity beginning in the early 1980's, and the other had appeared to have been forgiven a debt to the state of over $89,000. Neither has been resolved, with the first continuing to do business with the Medicaid Program and still owing the program approximately $1.7 million, and the other having sold the business and appealing the total amount owed of $93,507.10.

The Code of Federal Regulations states that the Medicaid agency has 60 days from the discovery of an overpayment to a provider to recover or seek to recover the overpayment before the federal share must be refunded. There are only two exceptions to this rule, which deal with the legally responsible party for payments involving third parties and probate collections. Department staff was unable to verify whether the federal share had or had not been returned for the above questioned payments.

The following information was reported on the Accounts Receivable Aging Report. It should be noted that this does not include Third Party Liability or Drug Rebate amounts.

UNDER 45 DAYS------$2,964,206.47

UNDER 90 DAYS------$4,466,121.84

OVER 90 DAYS---------- $118,321.48

OVER 120 DAYS------- $8,988,491.51

TOTAL---------- $16,537,141.30

The DMS reports that since September of 1993, it has collected $40,468.66 from recipient fraud. No information was given as to the outstanding balance.

Although drug rebate recoveries were requested from the DMS, accurate information was unavailable. However, the department did send a report explaining why the drug rebate accounts receivable are so unreliable and listing other problems associated with the drug rebate program.

The DMS reported in its June update that the department had increased its collections effort from $12.5 million in FY 92 to $16 million in FY 93. Additionally, the department has issued a request for proposals for services related to the outstanding third party liabilities.

DISCLOSURE INFORMATION

THE ISSUE: The Code of Federal Regulations requires that the Medicaid agency require providers and fiscal agents to disclose ownership and control information, along with information on a provider's owners and other persons convicted of criminal offenses against Medicaid, Medicare, or other Title XX programs.

BACKGROUND: In the initial study of the Kentucky Medical Assistance Program, disclosure of ownership information was not always available or current. A significant number of disclosures were found to be inadequate, because the information was incomplete or not given at all.

WHAT THEY ARE DOING: The DMS staff indicated that disclosure information is being provided by providers. They indicated this will be enhanced upon the implementation of a scanner in January or February of 1995.

Program Review staff have observed recent disclosures which fail to provide the necessary disclosure information.

In the June update the DMS indicated that disclosure information is available through a number of divisions throughout the Cabinet. The department indicated that through the use of the fiscal agent an automated tracking system is being updated. The department also indicated that 136 providers had been terminated for failure to disclose.

NARCOTIC DRUG CONTROL

THE ISSUE: Recommendation #11 of the study of the Kentucky Medical Assistance Program illustrated the need for the development of utilization guidelines and criteria.

BACKGROUND: Program Review staff identified a codeine compound as the second most prescribed drug by the Medicaid Program. Ad-Hoc reports clearly indicated the potential for abuse of narcotics in the system. Numerous newspaper articles and television broadcasts have drawn the same conclusion. The DMS appeared ineffective in its efforts or lack of efforts to address the situation.

WHAT THEY ARE DOING: The DMS referred the top 150 providers to the Department of Health Services for their review. Of those top providers 15 were referred to the Medical Licensure Board. Program Review staff attempted to contact the Medical Licensure Board, to determine the outcome of the referrals. It is important to note that no provider agreement has been terminated as a result of this activity, according to an official in the OIG.

DMS staff indicated the department, in conjunction with the contract extension with the fiscal agent, has been able to include the implementation of an enhanced prospective drug utilization review system, which will entail monitoring at the pharmacy of drug utilization. None of the persons interviewed by PRIC staff in relation to this review mentioned drug utilization review outcomes.

PRIOR AUTHORIZATION PROCESS

THE ISSUE: The prior authorization process has not been evaluated on its effectiveness to lower costs or prevent abuse.

BACKGROUND: The DMS uses its fiscal agent for prior authorizations of drugs and other medically related activities. The cost of this function was estimated at $1.3 million per year. Of the sixteen states surveyed by DMS staff regarding drug prior authorizations only three used a fiscal agent for this function. Although office hours for the prior authorization are 8:00AM to 4:30PM EST Monday through Friday, excluding holidays, DMS staff indicated that office hours were not a problem, even with the different time zones; the fiscal agent just back-dated the prior authorization request to the prescription date, if the request matched approved criteria.

Recently a Medicaid provider was mentioned in a news article as having approximately $1.5 million in questionable practices. Program Review staff requested an ad-hoc report for this time period. Of the 10,731 claims submitted, 2,389 received prior authorizations. It should be noted that the ad-hoc report did not determine whether the balance of claims was associated with the prior authorization.

WHAT THEY ARE DOING: No changes in the prior authorization process were identified to the PRIC staff.

DSI ELIGIBILITY AND MONITORING ACTIVITIES

THE ISSUE: Recommendation #4 addressed the need for an eligibility determination audit.

BACKGROUND: The DMS had never reviewed cases completed under the eligibility contract with the Department of Social Insurance to determine whether policies were interpreted and applied correctly.

WHAT THEY ARE DOING: The Commissioner of DSI indicated that local offices who appear to be experiencing problems in conforming to the eligibility contract will be monitored. Staff who have received specialized training will be deployed to the local offices to identify and correct problem areas.

The DMS indicated in its response to the Coopers and Lybrand finding that it is examining the current language in the existing interagency agreement between the DMS and DSI for eligibility determination. The feasibility of contracting on a per capita basis will be explored. Additionally, the practicality and cost-effectiveness of Medicaid-specific field staff will be explored.

KenPAC

THE ISSUE: Recommendation #1 indicated the CHR should require an independent evaluation of the KenPAC Program.

BACKGROUND: The goals of the KenPAC Program were to assure needed access to health care, provide continuity of care, prevent unnecessary utilization and costs, and strengthen the patient and physician relationship. Although the program had been described as savings hundred of millions of dollars, problems regarding utilization have been noted in various studies.

Although the OIG follow-up to the Progressive Health Study of Outpatient Hospital Services was not an evaluation of the KenPAC Program, the findings and recommendations of the OIG appear to be invaluable in identifying weaknesses of the program. The OIG found that approximately half of the patients in its test sample were KenPAC. The OIG stated that "over-utilization of the emergency room by KenPAC patients indicates a weakness in the program, since physicians should be involved with case management of these individuals".

WHAT THEY ARE DOING: The DMS has not conducted an evaluation at this time. The department indicated that it will have independent evaluators of the KenPAC Program and its other managed care initiatives.

RECOMMENDATION WORKSHEET
October 11, 1993

Recommendation #1: **KenPAC Should be Evaluated.**

The Cabinet for Human Resources should require an independent evaluation of the effectiveness of the KenPAC program. The program should be redesigned to address any deficiencies in cost containment, service utilization, program education, program availability or management fees. The evaluation should be completed before the wavier renewal application is submitted to the Federal Department of Health and Human Services.

AGENCY RESPONSE:	**STAFF RESPONSE/COMMITTEE ACTION:**
CHR: Agree. Will seek independent evaluation prior to submitting waiver renewal request in October, 1994. Will issue RFP in November, 1993 and have contract by February 1994.	Adopted by Committee 10/11/93

Recommendation #2: **MMIS Audit**

A private and independent audit of the MMIS system should be commissioned immediately by the Cabinet for Human Resources.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Has requested the Auditor of Public Accounts to conduct audit. Anticipate audit will be costly.	According to federal officials such an audit would be an "allowable cost"; thus federal matching dollars would be available. Adopted by Committee 10/11/93

RECOMMENDATION #3 : Trust Fund Audit

The Cabinet for Human Resources should audit the two funds on a regular basis, and in compliance with state statutes. The State Auditor's Office should provide copies of their audit to the Interim Joint Committees on Appropriations and Revenue and Health and Welfare, and the Program Review and Investigations Committee.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Have commissioned Auditor of Public Accounts to audit MART account. Will have annual audit of MART and MAIT accounts performed beginning in 1994. Estimate cost at $30,000.	Adopted by Committee 10/11/93

Recommendation #4: **DSI Eligibility Determination Audit.**

The Cabinet for Human Resources should expedite the signing of FY 1992-93 Interagency Agreement and perform internal monitoring of the contract by auditing policy interpretation and criteria for eligibility determination and related programs.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Final contract to be executed soon. Will take practicable steps necessary to ensure appropriate expertise is made available in connection with the subject audits.	Response does not indicate what steps the DMS will take to audit DSI activities related to eligibility determination and other responsibilities, such as transportation approval. Adopted by Committee 10/11/93

Recommendation #5: Policies and Procedures Governing Forgiveness of Debts.

The Cabinet for Human Resources should develop policies and procedures governing forgiveness of debts owed the Medicaid program. These policies should address criteria for determining financial hardship and provider disclosure information and should ensure compliance with federal and state laws. A single authority within the Department should be designated for reviewing and approving these exceptional practices and should ensure proper monitoring and tracking within MMIS.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Will have developed and have ready for implementation by January 1, 1994.	Unclear as to when policies will actually be implemented; or what, if any, interim action will be taken. Adopted by Committee 10/11/93

Recommendation #6: Review the Legality and Necessity for Making Advances and Discharges.

The Cabinet for Human Resources should determine the legality of making advance payments and discharging overpayments. If the Cabinet determines there is a legal authority to continue these practices, it should formalize the processes by developing regulations that will specify when, how and to whom advances and discharges should be made. In addition, regulations should specify a central authority for authorizing advances and discharges, as well as measures for tracking and monitoring the claims involved, and insure that these transaction are appropriately recorded and reflected in the management information system in a manner that will allow easy retrieval.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Will have policies and procedures ready for implementation by January 1, 1994, if necessary.	Unclear as to what, if any, interim action will be taken. Adopted by Committee 10/11/93

Recommendation #7: Develop Policies for Hardship Requests.

The Cabinet for Human Resources should develop policies to define hardship. In addition, policies and procedures should specify a central authority for authorizing payouts, types of documentation required to prove hardship, timeframes for submitting the documentation, appeal rights, and methods that will be used to verify provider documentation.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Will develop by January 1, 1994.	Unclear as to when implementation will occur or what, if any, interim action will be taken. Adopted by Committee 10/11/93

Recommendation #8: **Need for Policy and Procedures on Check Retention.**

The Department of Medicaid Services should develop policies and procedures that reflect applicable state and federal policies on check retention.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Will review procedures and practices. Believe current process complies with federal and state law. Necessary to motivate providers to comply with Medicaid program.	Although this may not be a violation of state or federal law, it is not an encouraged process. According to State Treasurer's Office, as of July 1, 1993, federal monies will not be affected until the check is cashed. Previously federal monies were drawn at the time the check was written. At the state level, this practice affects cash management practices through the timing of investments. Adopted by Committee 10/11/93

Recommendation 9 **The Need for Disclosures.**

The Cabinet for Human Resources should insure that disclosures are obtained from all provider types and kept current.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Will comply with federal requirements by January 1, 1994.	Adopted by Committee 10/11/93

Recommendation #10: DMS Should Be More Aggressive in Pursuing Overpayments and TPLs.

DMS should increase its efforts in the areas of recipient and provider overpayment recoupments. DMS should work more aggressively towards identifying potential TPLs and pursuing payment of TPLs, to increase cost savings in the Medicaid program. Strategies for TPLs that could be utilized to implement this recommendation include:

- **Performing data matches with more private insurance companies, to identify potential TPLs.**
- **Lowering the threshold on accident and trauma claims.**
- **Pursuing collection of identified TPLs more aggressively by not closing cases for lack of response.**
- **Investigating the feasibility of establishing a TPL collection unit under DMS.**
- **Investigating the feasibility of employing private collection agencies in TPL collection**
- **Considering the feasibility of billing Medicaid recipients if a potential TPL exists.**

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Attempting to develop in-house system. Intend to propose legislation to assist efforts.	Adopted by Committee 10/11/93

Recommendation #11: Development of Utilization Guidelines and Criteria.

The Department for Medicaid Services should develop guidelines and criteria to define appropriate utilization to meet recipient needs and recognized standards of health care.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Negotiating for a PEER review pilot project in nursing homes. Negotiating with EDS to review outpatient ancillary services.	Does not address areas of other services, such as pharmaceuticals, transportation, and durable medical goods. Criteria need to be reviewed and established in all areas so that proper utilization reviews can be performed to detect fraud and abuse and provide the legal basis for recoupment efforts and legal actions. MMIS system needs to be modified to provide audits and edits to detect exceptions to these criteria or guidelines. Adopted by Committee 10/11/93

Recommendation #12: **Freedom of Choice Waiver for Lock-in Recipients.**

The Department for Medicaid Services should study the effectiveness of amending the state plan to request a wavier to restrict freedom of choice provisions. The restrictions would allow the Department to assign a recipient placed on lock-in to a Medicaid provider in lieu of allowing the recipient to choose their lock-in provider.

AGENCY RESPONSE:	STAFF RESPONSE/COMMITTEE ACTION:
CHR: Agree. Will implement as soon as possible.	Adopted by Committee 10/11/93

APPENDIX B

APPENDIX C

APPENDIX D